

U.S. Navy Medicine

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U.S. NAVY MEDICINE

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1 From the Chief

2 Department Rounds

Protecting the Navy workplace . . . Coming up: NRMC Okinawa . . . Richard Jewell honored for work with alcoholics

5 Hospital Corpsmen, Then and Now

HMCS F.J. Scanlon

6 Enlisted Scene

Planning to reenlist? . . . Hoping to advance? . . . How to get "C" school training

7 NAVMED Newsmakers

8 Off Duty Mountain medicine . . . The sweet life

10 On Duty Medical care in the Belknap-Kennedy collision

13 Notes and Announcements

Pacific area medical/dental liaison office directory . . . Ten-day option eliminated . . . Dental officer training requests . . . Occupational health, anesthesiology meetings . . . Trauma symposium . . . HQ Marine Corps medical conference . . . Sixth Asian-Pacific Cardiology Congress

16 Soundings

Division Officers/Leading Petty Officers: New Help for Hospitals
HMCM T.G. Gardner, USN

18 Policy Instructions and Directives

21 Clinical Notes

Propranolol in Migraine Prophylaxis
LCDR R.C. Packard, MC, USN

22 Professional

Human Energy Requirements: A Simple Tool for Assessment in a Weight Control Program
LT S.R. Lamar, MSC, USN

26 Sublingual Dermoid Cyst: Report of a Case

LCDR M.B. Smith, DC, USN
CAPT B.J. DeVos, DC, USN

28 Scholars' Scuttlebutt Tax Change Hits Students

29 BUMED SITREP

COVER: When the USS *Belknap* and the USS *Kennedy* collided last November, the mass casualty system was equal to the test—thanks to careful planning and countless practice drills. Our cover, by PHAN R. Wilborn, shows a patient being transferred from the *Kennedy* flight deck to the deck edge elevator. For a report of Navy medicine's response to this crisis at sea, turn to page 10.

Medical Care Evaluation Programs



Photo by PH2 Terry Mitchell

Delivery of health care in the modern environment is undergoing more scrutiny and is being affected by more influences outside the medical community than at probably any time in history. At the same time, the medical community itself is striving to improve the health care being given and to find ways to quantify these improvements objectively. In this latter regard the Joint Commission on Accreditation of Hospitals has implemented what are considered standards for objectively evaluating the patient care given in a health care institution; to encourage the use of these standards, the JCAH has made their use a significant factor in the accreditation process.

On 1 March 1976, BUMEDINST 6320.54, "Medical Care Evaluation Program for Regional Medical Centers and Hospitals," was published, setting forth the official Navy position for guiding our medical centers and hospitals as they develop their own internal medical care evaluation programs. In addition, a BUMED SITREP was released this month which amplifies the Bureau's policy regarding compliance with JCAH standards. In brief, this policy encompasses three distinct but interrelated elements:

- *Patient care audit*—Evaluation of the quality of patient care rendered.
- *Utilization review*—Examination of efficiency in use of the institution and resources.
- *Credentialing*—The procedure for processing and evaluating applicants for clinical staff membership, and granting of clinical privileges.

These elements are purposely broad in scope and are intended to give wide flexibility for tailoring evaluation programs within the constraints and pecu-

liarities of the local center, as well as to encourage maximum effort in complying with the JCAH standards.

When this SITREP is received at our centers and hospitals, I urge that it be seen by all members of the clinical staff. One point stands out very clearly: *The local program cannot be developed by any other source.* It is essentially a local program to be developed, implemented and monitored by local staff clinicians. From a professional standpoint, participation by local practitioners in the development of the local Medical Care Evaluation Program presents an ideal opportunity to affect the manner in which health care is being delivered at *their* hospital or center. I cannot stress strongly enough that the entire local staffs should be familiar with the elements of the Medical Care Evaluation Program if their efforts are to be successful.

Navy health care practitioners provide services closely touching people's lives; they should be able to demonstrate to themselves and their patients that quality medical care is being provided. Medical care evaluation is one of the management tools to do just that. Your support of the Navy's program is earnestly desired.



Surgeon General of the Navy

Department Rounds

Navy medicine draws a bead on

TCE, Asbestos, and a Host of Hazards

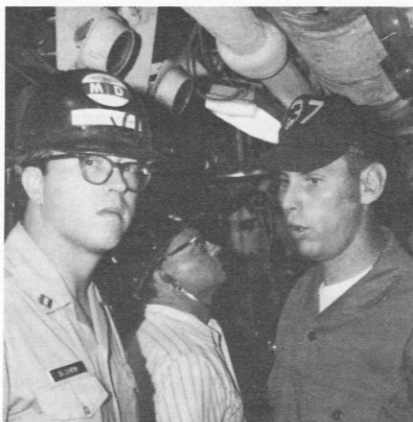
If someone told you your coffee was decaffeinated with trichloroethylene (TCE), you'd probably go right on drinking. After all, when supermarket products overflow with chemicals, one more in your coffee is nothing to write home about.

But you'd be wrong about TCE. Preliminary data shows that this photochemically reactive organic solvent is a potent liver carcinogen in laboratory mice and a possible cancer threat to humans. To protect Navy workers, BUMED recently issued a TCE alert. BUMED Instruction 6260.22 of 18 March 1976 urges commands to substitute the less toxic methylchloroform (1, 1, 1-trichloroethane) or perchloroethane when a solvent is needed. Also, Navymen regularly exposed to TCE will be placed under medical surveillance; industrial hygienists will monitor their workplace for adequate engineering controls and use of personal protective gear such as respirators and clothing.

TCE is no longer used to decaffeinate coffee—but it is used for industrial purposes. The Navy uses it mainly to degrease metal parts. Workers who inhale enough TCE vapor can experience disturbed vision, confusion, nausea and vomiting. More serious consequences such as liver and kidney injuries have been attributed, although rarely, to TCE overexposure.

The TCE monitoring program is one of many measures BUMED's Occupational and Preventive Medicine Division is taking to safeguard Navy workers' health. Commands are expected to begin annual workplace inspections of their own activities in FY77, supplemented by

random checks by the Navy Inspector General. The CNO's logistics section is establishing its own occupational safety and health program under the direction of CDR James Groff, a civil engineer; his staff will include full-time occupational health specialists.



Family practice resident LT J.A. Schenk (MC), left, learns about noise problems aboard the USS *Davis*

Besides helping set up the workplace inspection apparatus, BUMED's occupational health staff has been deeply involved with new weapons systems and new ships. Says CAPT George M. Lawton (MC), Occupational and Preventive Medicine Division deputy director, "We're trying to work with weapons developers at an early stage to eliminate, or at least control, unnecessary occupational health hazards." Failure to get involved early can mean expensive delays in the work while safety devices are installed. One example: workers servicing the new Mark 48 torpedo showed toxic symptoms which were traced to the torpedo's propellant,

Otto Fuel II. Development of the torpedo was held up while toxicology tests were done on the fuel and a ventilation system designed. To avoid similar problems in the future, Navy industrial hygienists are now testing propellants and exhaust products for the HERO, harpoon and cruise missile systems. Also, toxicology tests are performed on materials going into new ships; for instance, the Navy will test lubricants, fuels and general use consumables to be used on the new Trident submarine.

Possible carcinogens other than TCE continue to involve BUMED's occupational medicine staff. The problem of asbestos drew national attention in 1975 when the American Cancer Society criticized the Navy for not tracking down World War II shipyard workers who might have contracted mesothelioma or lung cancer from asbestos exposure. On the drawing board now is a proposal to study World War II Brooklyn Naval Shipyard workers, comparing the mortality of those who did and did not work with asbestos. The privately funded study would be conducted by a civilian investigator. One problem to be solved: the personnel records of civilian workers are virtually closed to non-federal medical researchers under the Privacy Act.

Although no asbestos may be used in Navy ships built after 1 January 1976 (manganese oxide materials or fiberglass insulation will be substituted), CAPT Lawton points out that there is still a lot of asbestos on Navy ships. BUMED and the CNO have issued several instructions directing commands on asbestos control.

In the mill is a detailed BUMED instruction on health monitoring of Navy jobs in which suspected carcinogens are used. On a broader scale, the National Academy of Sciences is reviewing a number of military occupations for all kinds of health risk. Results are not expected for at least two years.

Hearing conservation is also receiving close attention. The Sur-

geon General recently told commanding officers to set up hearing conservation programs, and to make sure sailors use ear protectors. The Health Sciences Education and Training Command has mounted a campaign to educate Navy men and women about noise perils. And the Naval Aerospace Medical Research Laboratory, Pensacola is studying hearing loss among ten Navy ratings exposed to high noise levels.

Although Navy occupational medicine has made substantial progress in eliminating health hazards aboard ship and at shore facilities, obstacles remain. Like everything, safety has its price tag. "Modifying a ship to conform with safety regulations is extremely expensive," says CAPT Lawton, "and removes the ship from operation for some time. Basic changes must be engineered for each ship individually."

Another roadblock: the future effect of on-the-job hazards is hard to take seriously today, CAPT Lawton says. "Everyone knows the dangers of cigarette smoking, but look at how many people still smoke. They're willing to take the risk." People often have too many immediate problems, he adds, to give much thought to preventing diseases that may or may not flare up in 30 years. CAPT Lawton advises Medical Department personnel, often untrained in spotting occupation-related health problems, to get out of their office and into the workplace to see for themselves exactly what hazards their patients face.

The key to eliminating hazards is safety awareness. If a corpsman sees that a shipboard machine generates too much noise, he can mark the equipment with stickers, available from naval supply points, that warn "Produces Hazardous Noise." Simple, inexpensive—and effective. A little propagandizing for on-the-job safety can go a long way, too. Workers don't usually risk their health deliberately—they are just unaware of the dangers.



U.S. Army Hospital Kuwae, Okinawa: Going Navy

Facilities

Okinawa Transfer

U.S. Army Hospital Kuwae, Okinawa will become Naval Regional Medical Center Okinawa when the Navy takes over the 18-year-old hospital in FY77.

The Navy Medical Department will also take over the Army's Makiminato dispensary and Evans dental clinic on Okinawa, and the Army regional medical laboratory at Sagami-Ono, Japan.

The switchover is the result of a drop in the number of Army units in Japan and Okinawa, and the increasing dominance of the Navy and Marine Corps in the Western Pacific.

Under the Navy, the hospital will become an independent regional medical center with regional dispensaries. Preventive and environmental medical activities will be carried out by a detachment of Preventive Medicine Unit (PMU) 6 in Hawaii. The Sagami-Ono laboratory will operate as part of Naval Regional Medical Center Yokosuka, Japan, under the direction of an officer-in-charge.

The Okinawa hospital has an operating capacity of 350 beds and can expand to 700. Besides providing a full range of specialty services for approximately 55,000 military, military dependents, and civilian personnel, the hospital also operates the military's Western Pacific burn center and radioisotope laboratory. When the Navy takes over, the hospital is expected to have 35 to 40 physicians.

The Sagami-Ono laboratory serves as the Army's Pacific Command blood bank and Western Pacific drug testing facility, and offers sophisticated services in pathology, toxicology, entomology, virology, bacteriology, parasitology and clinical chemistry.

Okinawa's climate is semi-tropical, with average temperatures from 52°F. in February to 90°F. in July; typhoons can strike anytime between May and November (the medical center was built to be typhoon-proof). All facilities normally available at a large military base are handy—commissary, exchange, post office, schools, religious services, recreation and entertainment. Local English language media include military radio and TV stations, two newspapers, and two civilian-operated radio stations.

For a Pioneer: A Medal

He had been an alcoholic, and he might have been one of life's permanent losers. Instead, he fought back. More than that, he helped other alcoholics fight back, too. And one day last March he stood with his wife while the Navy Surgeon General pinned on his lapel the Distinguished Civilian Service Medal. Richard Jewell, retired Navy commander and recovered alcoholic, was firmly in the winner's circle.

One of the highest federal honors ever given to a worker in the field of alcoholism treatment, the award was presented to Jewell for his pioneering role in founding the Navywide alcoholism prevention and treatment program.

Jewell began his volunteer work with alcoholic Navymen in 1965, eight years after retiring from the Navy. "I wanted to help people on the base who needed it," Jewell said in a recent interview in Washington, D.C., "because in those days most military doctors didn't know how to treat alcoholics. It wasn't a subject taught in medical courses."

After gaining his sobriety in the early 1960's, Jewell worked full-time with alcoholics at Naval Station Long Beach, California. "I wanted to show the doctors that there was a way out for alcoholics," he said. In 1969 he became a staff member of the Alcohol Rehabilitation Center, NRMC Long Beach. He retired from this position last year.

One of Jewell's early supporters was CAPT Joseph J. Zuska (MC), who headed the Long Beach ARC until his retirement in 1974. Along with several other Navy physicians, he encouraged Jewell to start group meetings and therapy sessions for alcoholics. But the doctors had no facilities to offer other than their own offices after hours. "So we be-



Richard Jewell receives award from Navy Surgeon General

gan with only a few people in a captain's conference room," Jewell recalled.

At first people were shy, frightened and hesitant to label themselves alcoholics. "We weren't entirely successful right away," Jewell said, "because none of us knew how to handle the situation. Gradually, by trial and error, we began to have some success in getting people off the bottle, and keeping them off."

Later he was given an empty quonset hut that had a bare assembly hall and some office space with a phone. "And that," he said, "was the beginning of our alcoholism clinic."

"Of course, everything wasn't roses right off," Jewell continued. "We had to fight battles from top to bottom to keep our clinic on base because some people were ashamed to have it there."

Jewell stressed that in those days alcoholism in the military was considered a disciplinary problem. Very few people understood that it was a treatable disease.

In 1967, two years after its establishment, the Long Beach "clinic" received official recognition and became the Navy's first alcohol rehabilitation center. Several years later, another center was opened in Norfolk, Virginia, using treatment and rehabilitation methods developed at Long Beach. Today, there are five major centers at naval bases around the country, 14 smaller units at naval hospitals, and more than 40 locally designated facilities at commands worldwide. Any Navy man or



Richard Jewell, with medal
A way out for alcoholics

woman who may have a drinking problem can walk in, or request to be sent to a center for treatment.

Recovery rates appear encouraging. According to official studies, from 1965 to 1975 more than 12,000 alcoholics have been given help; 70% have been successfully restored to duty.

To augment its program, the Navy has over 250 part-time alcoholism counselors. The Navy also offers training for full-time counselors, and publishes films and literature for Navy audiences.

Of his role in breaking the ground for alcohol treatment in the Navy, Jewell said, "I had the problem myself and beat it. I knew others could, too. I'd been in the Navy and so took my ideas to them. If I've helped, that's what I started out to do, and that's all I can ask for."

From Surgeon's Steward to Specialist: Hospital Corpsmen, Then and Now

HMCS Frank J. Scanlon

Holding sick call on a destroyer in the Atlantic . . . updating a Marine Corps unit's medical supplies . . . providing nursing care for newborns . . . wherever you find Navy hospital corpsmen, you can count on top-flight health care. Low in numbers but high on quality, corpsmen have come a long way since Congress established their rating in 1898. To mark the Hospital Corps' 78th birthday on 17 June, HMCS Frank J. Scanlon briefly charts its proud history:

Since the original group of 25 pharmacy technicians, thousands of men and women have worn the Hospital Corps' Geneva Cross and caduceus.

From the first surgeon's steward to today's highly trained and talented technicians, hospital corpsmen have been among the most versatile of Navy personnel. During even a short career, a corpsman's duty assignments can range from a busy regional medical center to challenging field duty with the Marines or sea duty with the fleet.

Wherever Marines and sailors have served, corpsmen have been with them. In fact, if quarters for muster, inspection and instruction were called for all corpsmen past and present, those answering "aye" could give us a complete picture of American naval history. John Wall, the Navy's first known loblolly boy, could describe the battle between the U.S. frigate

Constellation and the French frigate *L'Insurgente* on 9 February 1799. Alexander Wood, another loblolly boy, could chronicle life aboard the *Essex*. John Dymn could tell how Algerian pirates captured him with the crew of the *Philadelphia* at Tripoli.

Through the American Revolution, War of 1812, Civil War, Boxer Rebellion, World Wars I and II, and in Haiti, Korea and Vietnam, the men and women of the Hospital Corps set the highest performance standards. Although their titles changed—from loblolly boy to surgeon's mate, bayman, apothecary, pharmacist's mate, and finally hospital corpsman—their contributions were invariably significant. There were no supermen. We had our share of fools and wise men, workers and shirkers, outlaws and law-keepers. But we had our share of heroes, too: 21 corpsmen have received the Medal of Honor. Their pictures now have an honored place on the walls of the Hospital Corps school buildings where they learned the basics of their rate.

Today's corpsman can choose from some 46 medical specialties. But he—and now frequently she—is as versatile as his predecessors: operating room, physical and occupational therapy, and neuropsychiatric technicians are all able to provide basic patient care in addition to their specialized skills. Corpsmen have filled sandbags, built and manned battle dressing stations, manned general quarters stations, and heroically defended the sick and injured in their care.

What would loblolly boy John Wall say if he were asked to relieve HMC Robert M. Harris of Seal Team No. 2? Could he, like CAPT Albert J. Schwab, rise from corpsman to chief of the Medical Service Corps, overcoming captivity in a Japanese prison camp? How many early corpsmen would have earned a medical degree after leaving the Navy, then return to serve their shipmates as did former hospital corpsmen RADMs Joseph T. Horgan, William J. Jacoby, Jr., Paul Kaufman, Walter M. Loneragan, Edward J. Rupnik, and Charles L. Waite? Nurse Corps officers who followed the same corps-



April 1918: Navy hospital corpsmen in France behind the front lines.

HMCS Scanlon is on the staff of the Hospital Corps Division, Bureau of Medicine and Surgery (Code 34), Washington, D.C. 20372.

man-to-officer route include CDRs Joan McIntyre, Donna Barbarick, Margaret Whitesell, and LCDR Bobby Huskey.

It would take years of preparation to make loblolly boy Alexander Wood a suitable replacement for HM1 Robert Wida, Medical Department representative aboard the USS *Francis Marion*. John Dorn would have had to burn a lot of midnight oil to learn the job of HM3 Thomas E. Hardy, cardiopulmonary technician at Naval Regional Medical Center Great Lakes.



Corpsmen with lifelike dummy "Oscar"

In fact, early hospital corpsmen would have to hustle just to keep up with today's talented breed—men and women like HM3 Julio M. Maldonado of Naval Undersea Medical Institute; HM1 Jane Kroeze, a transplantation technician at Naval Medical Research Institute; HM3 Karl Farmer, recently transferred from the Nursing Service at Naval Regional Medical Center Charleston to the USS *McDonnell*; HM3 Archie H. Jahnke of Naval Regional Medical Center San Diego; or HM3 Daniel F. Gruendemann, attached to the 1st Battalion, 6th Marines, 2nd Marine Division.

They are strong, self-reliant, resourceful men and women, proud of their heritage and their jobs. Their accomplishments will make a fitting legacy for tomorrow's corpsmen.

Enlisted Scene

Planning to Reenlist?

If you plan to reenlist or extend your current enlistment, check with your career counselor or personnel office to make sure you are eligible. You should also review BUPERS Instruction 1133.22D for revised reenlistment criteria (part of the Reenlistment Quality Control Program) and terms of reenlistment by length of service. BUPERS Instruction 1133.25C placed hospital corpsmen in career reenlistment objectives (CREO) Group "E," which means you must obtain BUPERS approval before you reenlist or extend your enlistment if you have less than 10 years' day-for-day active military service. Read these instructions now, so you can reenlist at the time and in the way you prefer. Otherwise, you may be disappointed if your plans must be changed at the last moment.

Hoping to Advance?

BUPERS Notice 1430 of 2 February 1976 announced revised time-in-service and time-in-rate requirements for advancement to pay grades E-7, E-8 and E-9 (including active and inactive Reservists):

- Effective 1 November 1976: To advance to E-9 you must have 15 years of service and have been an E-8 for 3 years. To advance to E-8, you must have completed 12 years of service.
- Effective 1 January 1977: To advance to E-7 you must have 9 years in service. The time-in-rate requirement is 3 years as an E-6.

Despite these new requirements, E-8 and E-9 candidates who took the November 1975 exam, and E-7 candidates who took the January 1976 exam and were not promoted will still be allowed to compete for advancement in the November 1976 E-8/9 and January 1977 E-7 exams if they are eligible and recommended by their commands.

Advanced Training "C" Schools

Competition for advanced training "C" schools is keen. Quotas ("school seats") are limited, while requests for this training are almost unlimited. Not all applicants who meet qualifications for "C" school assignment can be selected. To ensure that the selection of students is fair, BUMED has established a "C" school selection committee which meets quarterly. Factors which influence selection are: the applicant's qualifications, projected rotation date, previous advanced training in another specialty, academic and on-the-job performance, and quotas in the school requested.

Training and personnel officers should make sure that requests for "C" school training are submitted on NAVPERS 1306/7 to BUPERS, through the Enlisted Personnel Manpower and Accounting Center (EPMAC) and BUMED. The applicant must meet prerequisites outlined in the *Catalog of Navy Training Courses*, NAVEDTRACOM Form 1500/1. All items on Form 1306/7 should be completed and verified by the applicant and his command. The application must include a command endorsement and appropriate enclosures (SF-88, SF-93, academic records and special examination reports).

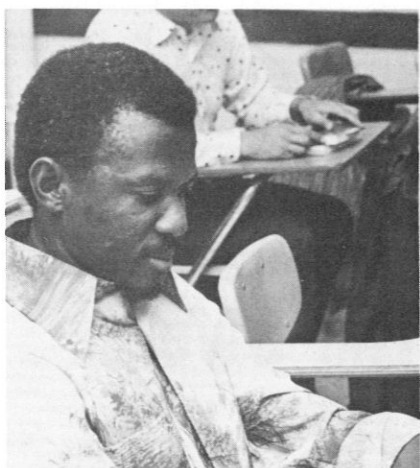
BUPERS sometimes receives requests to cancel "C" school training after an applicant has been selected, usually because the selectee doesn't want to perform the obligated service. Often it is too late to select another student for the training slot; the school seat is left vacant and someone else, who wanted the training, may lose the chance to get it. We cannot say it too often: *know the obligated service requirements before you apply for training.*

—HMCM Horace S. Anderson, Master Chief Petty Officer of the Force.



American Medical News

CAPT Spangler: Winning



HM1 Sapp: Dashing



Post 601: Exploring

NAVMED Newsmakers

Keeping up with retired Navy medical folks can leave you breathless, especially if you're chasing **Paul E. Spangler**, retired Navy surgeon and incurable jogger. CAPT Spangler, age 77, has huffed and puffed his way to many world records for his age group since he began running competitively last year. When we last heard from him, the fleet-footed sprinter had won five national championships and set four world records at the National Amateur Athletic Union's master meet in White Plains, N.Y. Says the indefatigable doctor, "I'm running more than ever and will never quit. It's never too late to start—I didn't get smart until I was 67."

When ABC-TV Nightly News reporter Bob Furnard needed the last word on hypothermia, he headed straight for Navy medicine's cold weather medicine experts: retired RADM **William Mills** (MC) and CAPT **Paul E. Tyler** (MC) of Naval Medical Research and Development Command. The interview, videotaped at National Naval Medical Center, warmed up a Saturday night news story on the dangers of spring camping and hiking.

For two hospital corpsmen at Naval Hospital Cherry Point, "Emergency" is more than a television program: it's the story of their lives as members of the Cherry Point rescue squad. HM3 **Ed Heath** and HN **Doug Conley** bring

know-how and quick reflexes to their work. They take information from callers, dispatch the ambulance, make sure that the emergency room is standing by, and check supplies in the medical crash kit. Their biggest headache: people who don't pull over for the ambulance. "People see the red light flashing, but they don't pull over because the siren isn't going," says HM3 **Heath**. "We usually don't sound the siren because it scares the patient. Many minutes could be saved if people would just pull off the road."

Education fever is sweeping NRMCMC San Diego, and no one's making the slightest effort to slow it down. A typical achiever is HM1 **Joseph Sapp**, who dashes from his full-time job in the lab of the blood donor center to evening class in health care administration at the Naval School of Health Sciences. More than 100 Navy go-getters assigned to the medical center are using their education benefits while on active duty.

Also making Navy medicine headlines this month were: HM1 **Charles C. Eggleston**, named Sailor of the Year aboard the USS *John F. Kennedy* for outstanding work as an X-ray technician . . . BUMED's chief biomedical engineer, CDR **John P. Swope** (MSC), who's just become the Navy's first board-certified clinical engineer . . . HN **Pat Schaeffer**, named Miss Military Little Creek, Virginia, and runner-up DT3 **Nancy Shemella**, both from Naval Amphibious Base Little Creek . . . and DT3 **Bruce Roemer**, who boxed his way to the 1976 all-Navy middleweight championships.

From today's medical explorers come tomorrow's health professionals—and if they're members of Medical Explorer Post 601 at NRMCMC Memphis, they may well choose careers in Navy medicine. Timothy Barrett recently received his Post's charter from explorer scout executive Bill Robinson, as advisers—LCDR **Joe Beene** (MSC), LTJG **Georgene Gibbs** (NC), and HMC **Doyles Grimes**—looked on. Not content at just turning teens on to Navy medicine, the medical center also sponsors a younger Boy Scout troop and a Cub Scout pack.

Off Duty

Mountain Medicine

The Medical Department's concern for human well-being doesn't end with its military obligations, as a remote Taiwanese mountain village recently found out.

LCDRs Jim Sebastian (MC) and Robert Post (DC), HM1 Wellman Wong, and DT2 Tom Deslauriers took annual leave in February to accompany civilian nurses and missionaries to Hau Cha Village. Their mission: to provide badly needed medical and dental care to the village's 120 families. Organized by China Free Methodist missionaries Harry and Ruth Winslow, the medical/dental team also included registered nurse Kathy Rees (a Navy wife), and interpreter John Thompson of the United States Information Service, Kaohsiung.

The group hiked 5600 feet up the mountains of south central Taiwan

to reach the isolated village. Native packers carried 85-lb supply packs up a 45-degree grade more easily than the visitors could manage the rough terrain with no gear at all.

In Hau Cha, LCDR Sebastian, an obstetrician and gynecologist formerly assigned to U.S. Naval Hospital Taipei, saw more than 200 patients in Ob/Gyn, geriatric, well and sick baby, and general sick call clinics. HM1 Wong—an independent duty hospital corpsman stationed in Tsoying—ran the makeshift pharmacy, sterilizing instruments over a crude wood-burning stove.

LCDR Post examined 185 patients, 60 of whom required dental extractions. (By day's end, 160 teeth had come out.) Both he and DT2 Deslauriers lectured on preventive dentistry; their instructions were translated by John Thompson into Mandarin Chinese, and then from Mandarin into the native language by a local teacher. The dental team also distributed 200 toothbrushes to the villagers, many of whom had never seen or used one.

In a village without electricity, the Americans relied on the sun—moving the dental clinic four times in one day to take advantage of every bit of sunlight. As the sun went down, the team turned to flashlights to continue their work.

Of all the revelations in store,

most surprising was the villagers' ability to withstand pain. In one case, LCDR Post administered local anesthesia to a third grader and removed 10 abscessed teeth in 20 minutes while the child showed not a trace of discomfort. "They're made of something stronger than we are," he said of the stoic villagers.

The Americans stayed in the villagers' homes and shared their meals—millet, roots, and fish. There developed the kind of compassion and respect that has always been the hallmark of good medical practice. "Without the total cooperation of the villagers, without their discipline and tolerance for discomfort, we could not have accomplished what we did," Dr. Post said at the end of the visit.

"The team's service to this village was given in a wonderful spirit of love," said Mrs. Winslow. "They will never be forgotten by the people they went to help."

—LT Paul deWitt, USNR

The Sweet Life

First it was "The Birds." Then "Jaws." And at Naval Regional Medical Center San Diego, there's a cast of thousands ready for another movie thriller: "The Bees."

But not to worry. According to the medical center's "Chief of Bee Swarms," CAPT John A. DeKrey (MC), there is no cause for alarm. The productive little insects are minding their own sweet business.

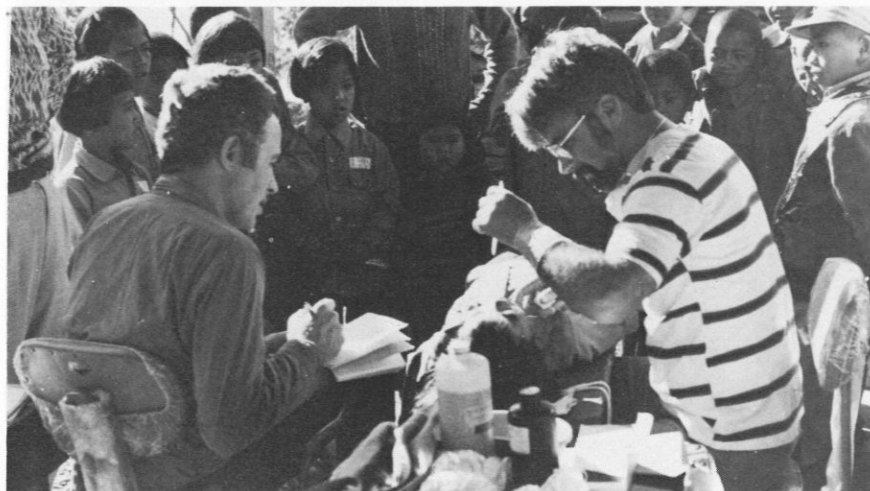
A staff anesthesiologist, Dr. DeKrey says he first got interested in his unusual hobby when he found a swarm of bees in his backyard about five years ago and made a hive for them. Soon another swarm arrived, and he made more room.

"I'm a farmer at heart," he says, "and raising bees is agriculture in its purest form."

Navy dentistry in the mountains



Crude stove turns sterilizer



Home wasn't the only place Dr. DeKrey found his bees. At the medical center he found a swarm on the North Patio, another by the Credit Union office, another near Building 26, and another in a manhole at the south end of Farenholt Avenue.

Dr. DeKrey says many people are scared to death of bees. A woman visiting his apiary recently was typically terrified when asked to don coveralls, boots, long gloves, hat, and net facemask. But she decided to be brave. After all, what harm were a few hundred bees simply buzzing around her face, arms, and legs? She was relieved when the bees did only what they're supposed to do: make honey.

"There's no need for fright," Dr. DeKrey says. "Most people are stung by wasps, not bees. Bees only sting if you molest or anger them—if you step on one, for example. Really, bees are among the world's most beneficial insects."

And among the most productive as well. Dr. DeKrey has harvested a ton of honey in one year from his apiary. After bottling the honey, he gave many jars to friends and patients. And when the hospital sponsored a fund-raising bazaar, the Department of Anesthesiology made out like bandits from its honey sales.

The 32 boxes stacked in Dr. DeKrey's apiary (four boxes per stack) don't look like beehives. They resemble drawers removed from a chest. In each of these "drawers" are 10 wood frames holding honeycombs. On each honeycomb, hundreds of bees make enough honey to feed the queen bee and the up to 2,000 soon-to-be-hatched eggs she lays every day.

In each hive, the queen bee is the center of attention, the worker bee the backbone. Worker bees produce honey from the nectar and pollen they collect. Queen bees, who never leave the hive, live up to eight years, Dr. DeKrey says, but worker bees usually live only six weeks. "The worker bee's life span is directly related to how much work it

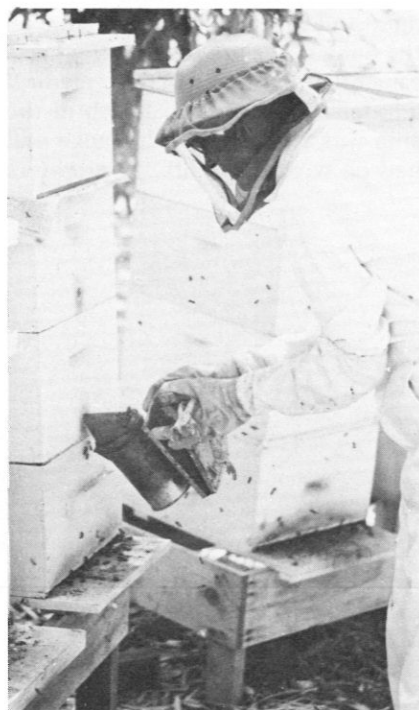
does. A bee can literally work itself to death."

Drones are male bees whose only purpose is to mate with a queen. Fed by the worker bees, drones cannot sting, and their life span is short, sometimes just one season.

Dr. DeKrey checks his apiary once or twice a week. "You can tell how things are going in the hive by whether the bees are flying or sitting around. Sometimes when a queen bee dies the bees act very peculiarly. They may sit around and mourn. Bees depend on their queen very strongly."

Dr. DeKrey has had only one problem with vandalism in the apiary. "One morning I found someone had removed the lid from one of the hives," he reports. "He was probably trying to get some honey. I don't think he succeeded because about 20 feet away I saw the lid lying on the ground." Evidently, the would-be burglar was chased away by an indignant bee household.

Taking care of the apiary is not difficult, says Dr. DeKrey, but harvesting the honey is more com-



CAPT DeKrey tends a hive



When full, this honeycomb will hold 5 lbs of sweet stuff.

plicated. "The bees need to be encouraged to work, and need to have lots of elbow room. If the hive gets too full, the bees will loaf and not produce honey." Harvesting the honey gives the bees the room they need to make more.

The harvesting process is a full weekend of work for Dr. DeKrey, depending on how many honeycombs or frames he has to handle. Bees build their honey-filled cells on the frame's waxy comb. When full, each frame holds about five pounds of honey.

To remove the frames from the hives without angering the insects, Dr. DeKrey blows the bees off with a vacuum cleaner. Then he takes the frames to his home and, with a hot knife, cuts off the wax residue that caps the honey. He then spins the frame in an extractor, and strains the honey he gets through a cheesecloth. Then it's into bottles and onto the table.

Bee fever is apparently contagious at San Diego. HM1 Howard A. Williams keeps two hives near his office. He has captured swarms at the medical center, in an air conditioner and near the Naval School of Health Sciences.

San Diego's bees and beekeepers are looking forward to the day when Hollywood starts filming "The Sting—Part II."

—Suzanne Choney, *Dry Dock*, NRMCSan Diego, California 92134. Photos by HN Mark Steely.



USS *Belknap* after the collision

On Duty

Collision at Sea

When the guided missile cruiser USS Belknap collided with the aircraft carrier USS John F. Kennedy last November, medical crewmembers saved lives through their quick action and superb skills. In this first-hand report, CDR James Wenger, senior medical officer aboard the Kennedy, tells how mass casualties were handled during the crisis:

At 2205 on 22 November 1975, the collision alarm sounded on the USS *John F. Kennedy*, followed by a call to general quarters. Immediately the ship's midsection was enveloped in dense, choking smoke that seemed to be coming from the port side. The smoke was so intense that all patients and most hospital corpsmen had to be evacuated from sick bay. The smoke also prevented the medical officer and medical administrative officer from reaching their stations in sick bay and damage control central. Since we didn't know the condition of the rest of the ship, we routed patients forward along the starboard passage to the hangar deck.

By patching bits of information together, we learned that the *Kennedy* and the USS *Belknap* had collided, causing fires in both ships.

Material condition Zebra was set: watertight doors and hatches were closed to prevent fire from spreading from one compartment to the next. A skeleton crew, equipped with survival support devices, manned sick bay. Because of a serious fire on the flight deck, the CVW-1 flight surgeon and regularly assigned hospital corpsmen manning the battle dressing station there were joined by corpsmen from the main battle dressing station.

Our three other physicians, our oral surgeon, and a team of corpsmen and stretcher bearers met on the hangar deck to discuss the mass casualty plan with the medical administrative officer. Much of the ship was still filled with smoke and had no working lights. Firefighters

were still working on the flight deck and in the port sponson.

When further reports told us that the *Belknap* fire had caused secondary explosions, we prepared for a large number of casualties from both ships. The forward battle dressing station and forward mess deck would be our main treatment areas until sick bay was restored. The #1 deck edge elevator area was designated as emergency forward battle dressing station and stocked with supplies and equipment from portable medical lockers and first-aid boxes.

Casualties. Our plan for evacuating *Belknap* patients was to help them to the flight deck, down to the hangar deck via #1 or #2 starboard deck edge elevators, then down



USS *Kennedy*: Casualties were amazingly low

upper stage bomb elevators #1 or #3 to the forward mess deck. Casualties would board the *Kennedy* from the USS *Hart* and USS *Dale*—two ships assisting in the rescue—to be evacuated to Branch Dispensary Sigonella and Naval Regional Medical Center Naples. Flight deck crewmembers who had seen the *Belknap* burn and explode predicted that 100 to 200 severe casualties would arrive.

The most seriously injured men began arriving from the *Belknap* by helicopter at 0230, after partial treatment by corpsmen and the CVW-1 flight surgeon. The men were badly burned; two had severe fractures of the upper arms. All were triaged, treated, and held at the forward battle dressing station until sick bay was smoke-free and ready to receive them at 0300. We drew blood specimens, inserted subclavian lines and indwelling catheters, stabilized fractures, and cleaned and debrided the wounds, redressing them with sulfamylon. Tetanus toxoid and prophylactic antibiotics were administered. By this time we had drawn 20 units of the four most common types of blood from our walking blood bank in the Marine detachment.

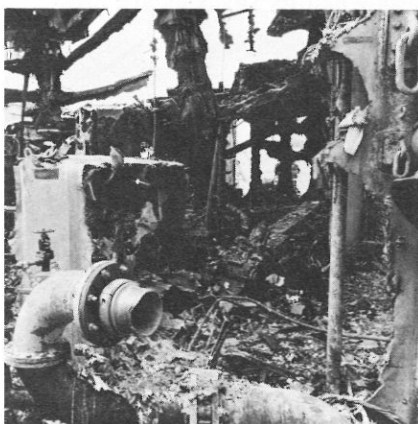
About 0400, a Nurse Corps officer and chief hospital corpsman came by helicopter from the Sigonella branch dispensary to help care for five critically injured patients. They left with six litter patients—three from the *Kennedy* sick bay and three from the *Dale*—whose condition had stabilized. All seriously injured patients were accompanied ashore by a hospital corpsman trained in search-and-rescue.

At 1000, with 46 patients aeromedically evacuated, our exhausted crew caught a few minutes of rest as two physicians from NRMCM Rota, Spain arrived with additional supplies.

Aboard the *Kennedy*, our casualties were amazingly low: one asphyxiation, three minor smoke inhalations, and two minor hand burns. Damage to the ship was



Injured men are brought by helicopter to the *Kennedy*



Damage aboard the *Belknap*

greater: a large fireball had rolled across the *Kennedy* flight deck, port sponson fires blazed until 0500 and reflashed for 24 hours after the collision, and three of four main machinery rooms were knocked out by dense smoke.

The USS *Kennedy* and its Medical Department performed effectively in this crisis because we were prepared. Our emergency gear was in place, up to date, and ready to go. Our only problem: some sulfamylon manufactured in 1973 had turned brown and grainy, despite its 36-month shelf life; this may have been caused by the high ambient temperature in the storage space. (NRMCM Naples later reported the same problem with sulfamylon made in 1970.)



Crewmember at memorial service

Our mass casualty system worked because we planned it carefully and conducted many practice drills. We correctly planned to treat patients at the hangar deck triage station or the forward battle dressing station, keeping them out of sick bay until that area was completely restored.

We reserved sick bay for serious and critical cases, brought one at a time from the forward battle dressing station where they had been expertly managed by dental officers, dental technicians and battle dressing station corpsmen. Men with slight injuries were treated elsewhere. This system allowed the ship's surgeon, the orthopedic surgeon assigned on temporary additional duty, and the senior dental officer to complete a full evaluation and start treatment before the next patient arrived.

Success. Although damage control central and sick bay were knocked out, the flexibility of our mass casualty plan ensured its success. As the lack of *Kennedy* casualties became clear, personnel assigned to the aft battle dressing station and the forward and aft auxiliary battle dressing stations were rotated to the flight deck, hangar deck or sick bay, or sent to get some sleep. The part of the crew that rested was ready the next morning to man battle dressing stations and resupply portable medical lockers and first-aid boxes.

We learned some important lessons from this experience:

- Information about emergencies must be sent through reliable channels so the shore facility can accurately assess the situation. In our case, lack of timely information about the number of casualties hindered precise planning: the response was too great for our need. NRMC Naples, informed two hours after the collision that there had been a major accident at sea and told to prepare for large numbers of casualties, devised a plan to supplement Sigonella branch dispensary personnel with physicians and corpsmen from NRMC Rota. The 2nd Medical Evacuation Group at Rhein-Main, Germany was also alerted to stand by for evacuation from Naples. Much of this preparation, it turned out, was unnecessary.
- Keep medical personnel aboard ship unless there is a good reason to dispatch them. Our medical officer

did not know that the CVW-1 flight surgeon had been directed to leave the flight deck battle dressing station and report to the *Hart*. Some of our medical decisions were therefore based on the erroneous assumption that a physician was still on the flight deck.

- Moving many patients in rigid litters up and down shipboard ladders is virtually impossible. Alternative methods should be worked out.
- The Coast Guard flotation stretcher should be standard equipment. The standard shipboard high-line flotation stretcher is awkward for transferring large numbers of patients by helicopter, and is useless when its shackles are lost.



The *Belknap* is towed into Naples

- The easiest way to handle patients who require flotation gear is to put a Stokes litter inside the Coast Guard flotation litter and then remove only the patient and inner stretcher. This makes it much easier to move patients with burns or spinal cord injuries.
- Have enough stretchers, especially Stokes litters, before deployment. Many of the *Kennedy*'s litters are painted white and bright orange to make them easily visible; their location is stenciled on the wood so they can be restowed quickly. Since handling lines and straps can be easily pilfered, an extra supply of restraining straps should be available. Also, the handling lines on Stokes litters are

cumbersome when moving patients onto helicopters and down crowded passageways; especially aboard aircraft carriers, Stokes litters should not be required to have handling lines unless the litters are used to carry patients up and down ladders.

- Don't count on storeroom supplies. Dense smoke made our two main storerooms inaccessible for several hours. Prior dispersal of intravenous solutions, dressings, and resuscitative equipment was our only preparation for the anticipated deluge of patients.

- A flexible mass casualty plan is essential. One can never predict the kind of crisis that tests a ship's medical capability to the limit. Have a plan, and practice it often. For flexibility, someone in damage control central should be familiar with medical care logistics. Our medical administrative officer, who is assigned to the control center, returned there when it was cleared of smoke and secured good patient movement routes around the firefighting.

- Crewmembers assigned to sick bay during mass casualty situations should stay where patients are initially received, in our case at the first major battle dressing station and then in the main battle dressing station. They are then better able to record patient flow. We did not have such a recorder, and it was only through elimination that we could later identify three patients moved from shipboard helicopters directly to the first shore-bound helicopter.

- A designated medical emergency phone circuit or speaker system is vital to organize medical resources. The circuit should serve the sick bay, flight deck, forward and aft battle dressing stations and damage control central. Our standard ship's telephone system and damage control circuits were almost worthless.

- Survival support devices were useful when living and working areas were evacuated. Each man should have at least one such device, and know how to use it. □

Notes & Announcements

PACIFIC AREA MEDICAL/DENTAL LIAISON OFFICE DIRECTORY

BUMED Notice 6000 of 12 March 1975 requires all naval hospitals and regional medical and dental centers to establish a fleet liaison office to support personnel assigned to

operational billets. A directory for the Atlantic Fleet appeared in *U.S. Navy Medicine* in April 1976. Below is an updated directory of offices in the Pacific Fleet.

NRMC SAN DIEGO, CALIF.

Medical Liaison Office

CAPT M.J. Valaske, MC, USN
LT M.J. Benson, MSC, USN
HMCM M. Luchter, USN

Commercial

Telephone
(714) 233-2415
(714) 233-2641
(714) 233-2421/22

Autovon

727-3850
727-3850
727-3850

Dental Liaison Office

CAPT E.F. Sobieski, DC, USN
LT G.R. Harrington, MSC, USN
DT1 B.D. Goains, USN

(714) 437-2955
(714) 235-1177
(714) 235-2171

958-9955
958-1534/1176
958-2171

NRMC CAMP PENDLETON, CALIF.

Medical Liaison Office

CDR A.N. Urbanc, MC, USN
LT E.C. Wigle, MSC, USN
HMCM D.L. Dittenhauser, USN

(714) 725-1458
(714) 725-1343
(714) 725-1340

993-1458
993-1343
993-1340

Dental Liaison Office

CAPT C.G. Strange, Jr., DC, USN

(714) 725-1200

993-1200

NRMC LONG BEACH, CALIF.

Medical Liaison Office

CAPT F.C. Leisse, MC, USN
LT R.L. Ruoff, MSC, USN
HMCS G. O'Keefe, USN

(213) 420-5447
(213) 420-5404
(213) 420-5389

873-9447
873-9404
873-9389

Dental Liaison Office

LT K. Vance, DC, USN
LT A.E. Kennedy, MSC, USN
DTCS A.T. Evangelista, USN

(213) 547-7436
(213) 547-7436
(213) 547-7436

360-7436
360-7436
360-7436

NH PORT HUENEME, CALIF.

Medical Liaison Office

CDR W.L. Lovett, MC, USN
LCDR R.P. Bauley, MSC, USN
HMCS L.A. Wink, USN

(805) 982-4501
(805) 982-4501
(805) 982-4501

360-4501
360-4501
360-4501

Dental Liaison Office

Same as Dental Liaison Office,
NRMC Long Beach, Calif.

NRMC OAKLAND, CALIF.

Medical Liaison Office

CAPT D.Q. Wilson, MC, USN
LT J.F. Renish, MSC, USN
HMCM R. Brown, USN

(415) 639-2115
(415) 639-2041
(415) 639-2357

836-6141
855-2041/2043
855-2358/2357

Dental Liaison Office

CAPT J.W.R. Anderson, DC, USN
LT S.R. Hixson, MSC, USN
DTCM J.N. Stutz, USN

(415) 765-5684
(415) 765-6892
(415) 765-6892

869-5554
869-6892
869-6892

NRMC BREMERTON, WASH.

Medical Liaison Office

CDR R.A. Nelson, MC, USN
CDR C.W. Bollinger, MC, USN
LTJG V.M. Wilson, MSC, USN
HMC M. Barker, USN

(206) 478-4204
(206) 478-4258
(206) 478-4415
(206) 478-4367

439-4204
439-4258
439-4415
439-4367

Dental Liaison Office

CAPT J.E. Miller, DC, USN
DTCM D.E. Denton, USN

(206) 478-2213
(206) 478-2213

439-2213
439-2213

NH WHIDBEY ISLAND, WASH.*Medical Liaison Office*

CDR J.P. Senn, MC, USN
 LT J.L. Raymond, MSC, USN
 HMCM W.B. Sprague, USN

*Commercial**Telephone*

(206) 257-2068
 (206) 257-2640
 (206) 257-2028

Autovon

820-2068
 820-2640
 820-2028

**NAVREGMED CLINIC PEARL HARBOR,
OAHU, HAWAII***Medical Liaison Office**Pearl Harbor*

CAPT L. Eske, MC, USN
 LT R.F. Figura, MSC, USN
 HMCS D.A. Martinez, USN

(808) 471-1256
 (808) 471-1256
 (808) 471-1256

430-0111
 430-0111
 430-0111

Barbers Point

CAPT N. Sanborn, MC, USN
 LT B.T. Sparks, MSC, USN
 HMCM N. Perea, USN

(808) 684-2205
 (808) 684-2205
 (808) 684-2205

430-0111
 430-0111
 430-0111

Kaneohe

CAPT L.R. Fout, MC, USN
 LT R.E. McKee, MSC, USN
 HMCS T.M. Daniels, USN

(808) 257-3365
 (808) 257-3365
 (808) 257-3365

430-0111
 430-0111
 430-0111

Dental Liaison Office

LT J.E. Morley, DC, USN
 LT D.J. Todd, MSC, USN
 DT2 D. Ellenburg, USN

(808) 471-9636
 (808) 471-9636
 (808) 471-9636

430-0111
 430-0111
 430-0111

NRMC GUAM*Medical Liaison Office*

CAPT R.B. Wright, MC, USN
 LTJG J.E. Soliday, MSC, USN
 HMCM R.R. Huemme, USN

344-9329
 344-9335
 339-4224

388-1110
 388-1110
 388-1110

Dental Liaison Office

CDR M. Ervin, DC, USN
 LCDR L.R. Massen, MSC, USN
 DT2 J.H. Thomas, USN

339-5266
 339-5146
 339-3175

339-8147
 339-8147
 339-8147

NRMC SUBIC BAY, R.P.*Medical Liaison Office*

CDR J.B. Lench, MC, USN
 LTJG T.A. Kulcsar, MSC, USN
 HMC A.A. Arreola, USN

885-9213
 885-9213
 885-9213

844-1101 } Ask operator
 844-1101 } for 5-9213
 844-1101 }

Dental Liaison Office

CAPT N.H. Tracy, Jr., DC, USN
 DT1 A.S. Cruz, USN

884-3245
 884-3245

844-1101 } Ask operator
 844-1101 } for 4-3245

NRMC YOKOSUKA, JAPAN*Medical Liaison Office*

CAPT R.C. Myers, MC, USN
 LCDR T.E. Thomas, MSC, USN
 HMCM J.R. Allmond, USN

234-7134
 234-7134
 234-7639

234-1110 (x7134)
 234-1110 (x7134)
 234-1110 (x7639)

Dental Liaison Office

CAPT W.R. Martin, DC, USN
 DT1 D.M. Bell, USN

234-7140
 234-7140

234-1110 (x7140)
 234-1110 (x7140)

U.S. NAVAL HOSPITAL TAIPEI, TAIWAN*Medical Liaison Office*

LCDR J.W. Aldis, MC, USN
 LT L.S. Watts, MSC, USN
 HMCM W.E. Cox, USN

871-5711
 871-5711
 871-5711

723-5228
 723-5260
 723-5279

Dental Liaison Office

CAPT H.S. Samuels, DC, USN
 DTCS P.B. Worland, USN

871-5717
 871-5717

723-5238
 723-5238

TEN-DAY OPTION ELIMINATED

Officers and enlisted personnel will no longer have ten days to retire or transfer to the Fleet Reserve rather than accept permanent change of station orders. The Bureau of Naval Personnel (BUPERS) cancelled the ten-day option after manpower studies showed that it contributed to an imbalance in sea/shore rotation and staffing. BUPERS Note 1800 of 12 March 1976 implements the change.

DENTAL OFFICER TRAINING REQUESTS

Dental officers must apply by 1 August 1976 for full-time advanced training starting in the summer of 1977. (BUMED's Dental Officer Training Committee meets in early September.) Officers should apply to the Naval Health Sciences Education and Training Command, Code 5, following new procedures described in BUMED Notice 1500 of 12 June 1975. The *Manual of the Medical Department* (Chapter 6, Section XVI, Articles 6-122—6-132) is being revised to reflect these new procedures.

Dental officers should also adhere to the above BUMED notice when applying for part-time inservice and outservice training, professional board review courses, consultant and lecture programs, short courses, seminars and workshops.

The Navy Dental Corps needs officers with public health training; one-year public health residencies at civilian institutions are available.

Since there are currently enough dental officers trained at the postdoctoral fellowship level, applications for such training are not encouraged.

OCCUPATIONAL HEALTH, ANESTHESIOLOGY MEETINGS SET

The 19th Navy Occupational Health Workshop will meet in Charleston, South Carolina, from 27 September to 1 October 1976. For details contact Ms. Barbara Halterman, Navy Environmental Health Center, 3333 Vine Street, Cincinnati, Ohio 45220. Or phone (Area code 513) 684-3863, Autovon 989-3863.

The Navy's Seventh Annual Anesthesiology Symposium, a refresher course on "Problems in Anesthesia," will meet 9-11 September 1976 at Naval Regional Medical Center Portsmouth, Virginia. For information, contact CAPT R.H. Norton (MC), Box 455, Naval Regional Medical Center Portsmouth, Virginia 23708.

TRAUMA SYMPOSIUM HELD AT NRMC LONG BEACH

Active-duty and Reserve naval medical units in California worked together on a one-day Trauma Symposium held 13 March 1976 at Naval Regional Medical Center Long Beach, California. The symposium was planned by CAPT E.P. Rucci (MC), CO of NRMC Long Beach, and CDR Attila Felsoory (MC, USNR-R), CO of Naval Regional Medical Center 5819, Encino, California.

Some 228 active-duty, Reserve and civilian physicians, dental officers, nurses and paramedics shared their expertise in management of orthopedic problems; high velocity missile wounds; chest, tracheal, bronchial, head, spine and urogenital injuries; blunt abdominal trauma; forensic medicine and ballistics; triage and mass casualty handling. Attendees received eight hours of continuing education credit from the International College of Surgeons.

HQ MARINE CORPS MEDICAL CONFERENCE

How to provide better health care to the Fleet Marine Force—that was the subject of a medical conference held 2-6 February 1976 at Headquarters Marine Corps in Washington, D.C. Senior medical officers of major Marine Corps commands, Headquarters Marine Corps, and the Marine Corps Development and Education Command attended the meeting, along with staff members from BUMED and the Naval Medical Materiel Support Command. Conferees discussed the organization of Marine Amphibious Force medical elements under the combat service support concept. Also covered were medical organization tables, Navy manpower allowances, and redistribution of Navy personnel within the combat service support organization.

Similar meetings are planned for the future to provide an exchange of ideas among experts in Fleet Marine Force operational medicine.—BUMED Code 54.

SIXTH ASIAN-PACIFIC CARDIOLOGY CONGRESS SET FOR 3-8 OCTOBER 1976

The Sixth Asian-Pacific Congress of Cardiology will be held in Honolulu, Hawaii, 3-8 October 1976. For program and registration information, contact CAPT D.R. Canete (MC, USNR), Hawaii Heart Association, 245 N. Kukui Street, Honolulu, Hawaii 96817.

Division Officers/Leading Petty Officers: New Help for Hospitals

HMCN Thomas G. Gardner, USN

During recent years, the status, authority, responsibility, and accountability of the petty officer has been seriously eroded. The cause of this change is not the major issue. The real issue, and the task at hand, is to restore the petty officer's image and status, to strengthen the Navy by making the petty officer more useful.

Many problems arise when petty officers do not participate fully in accomplishing the mission. Three trouble areas which have the greatest effect on morale and productivity are:

- *Communications.* A communications gap may exist when people are unsure of command policies, and do not know what to expect from the command or what the command expects from them.
- *Petty officer development.* The Navy stresses continuous learning in professional and management areas. If petty officer participation and command support for petty officer growth are lacking, both areas suffer. The more noticeable loss will be in leadership and management.
- *Administration.* Good management requires flexible leadership at each level of supervision. If supervisors lack this quality the overall capability of the unit is diminished.

Some of these leadership/management deficiencies were noted at Naval Regional Medical Center, Great Lakes, Illinois. To correct them, we instituted a Division Officer/Leading Petty Officer Program (DO/LPO) in February 1975. The concept is not new, its feasibility and effectiveness having been amply demonstrated in shipboard organization. But because the organizational structure of a naval regional medical center is so different from a naval vessel's, we had to find our own answers to a number of unique problems.

By organizational structure, the medical center's senior medical officers, ward medical officers, and chiefs of services are responsible for the administration

(including personnel management) of their respective clinical areas. It would logically follow that these individuals would be the ideal choice for the job of division officer. However, in medical facilities such assignments are frequently impractical. Many officers spend long hours in surgery, clinics, and meetings, or have other duties which keep them from serving as division officers. Some enlisted personnel, particularly those on evening or night duty, rarely see their division officers; other staff members work in areas remote from their supervisor's jurisdiction. Nevertheless, the division officer concept, as it is designed to function in the Navy, cannot be summarily discarded because of these difficulties.

IMPLEMENTING THE CONCEPT

Implementing the DO/LPO concept at NRMHC Great Lakes presented many problems. Chief among them was identification of division officers and leading petty officers with enough experience and leadership to train and guide junior enlisted personnel. Our solution: use Medical Service Corps officers with prior enlisted service, and augment this group with selected Nurse Corps officers and Medical Service Corps officers without enlisted service.

We selected leading petty officers (LPO's) based on their seniority, maturity, experience, and leadership potential. Most of the responsibility for implementing the program rested with the LPO, who had better rapport with junior enlisted personnel. Because few senior petty officers were assigned to wards and clinics, we had to draw LPO's from other work areas. Many LPO's therefore became responsible for the welfare and morale of enlisted personnel assigned to work areas where the LPO has no direct authority over the daily performance of his charges.

We named one division officer and one LPO for each 20 to 25 enlisted personnel, E-6 and below. Division assignment was by ward, clinic, branch or administra-

HMCN Gardner is master chief petty officer of the command at Naval Regional Medical Center, Great Lakes, Illinois 60088.

tive function (e.g., Supply, Personnel, Security). One DO/LPO team might be responsible for the enlisted personnel on one or more wards, as well as an administrative office.

DUTIES AND RESPONSIBILITIES

The directive implementing the program outlined the following minimum duties and responsibilities of the DO/LPO team:

Conduct division meetings, at least monthly, to discuss policy and actions impacting on personnel, base services available, various training programs available, etc.

Promote and encourage qualified personnel to consider the advantages of a Navy career.

Ensure that individual performance is recognized and rewarded.

Personally interview individuals placed in disciplinary status. Take corrective action within the petty officer's limits of authority. Attend mast proceedings.

Review periodic evaluations, and discuss with the individual the significance of these evaluations.

Encourage and assist personnel to prepare for advancement in rate and to obtain off-duty education.

Be available for discussion of personal problems. Provide information and guidance to help individuals solve personal problems and progress professionally and personally.

Ensure that personnel are fully aware of and adhere to regulations.

Ask assigned personnel to suggest ways to improve work methods, and to conserve time, labor, and funds.

Instill a sense of personal pride and responsibility in junior personnel by explaining the vital role each individual plays in accomplishing the command's mission.

Set a good personal example for junior Navy members.

Several problems arose when the program went into effect. We needed to improve our method of com-

municating command policy. A few of the younger, less experienced members of the DO/LPO teams did not participate fully; on rare occasions, we had to replace a team member whose efforts did not meet our standards. Also, because of working hours or the physical location of some departments, it was frequently difficult for the DO/LPO team to arrange group meetings, or to provide the necessary monitoring.

We are trying to solve these problems by:

- Giving each DO/LPO a copy of policy statements which directly affect members of the command (e.g., liberty, leave, advance pay, assignment, grooming standards).
- Providing leadership/management training for DO/LPO personnel. We send people to local programs sponsored by Chief of Naval Personnel, and also provide short-term training sessions conducted by members of the medical center staff.
- Monitoring the work of the DO/LPO teams through team meetings, chaired by the medical center or director of administrative services.
- Ensuring that DO's and LPO's have time to conduct meetings, and counsel and support division members.
- Inviting each DO/LPO to attend a formal nonjudicial punishment session and ensuing discussions to become familiar with the command's philosophy regarding discipline.
- Requiring monthly reports to the master chief petty officer of the command of topics discussed, complaints, and beneficial suggestions obtained through division meetings.

(Continued)

BUMED RESPONSE

The excellent program HMCM Gardner describes is already in operation (perhaps with some modifications) at other naval regional medical centers.

If it is true that in some areas the status, authority, responsibility and accountability of the Navy petty officer has been seriously eroded, we should be concerned about the cause of this decay. The cause must be identified and eliminated before the problem can be solved.

I agree that the petty officer's image is lower today than in years past, but many petty officers have not accepted their responsibilities nor exercised their authority as they should. The petty officer's status may have been given away rather than taken away or eroded.

To avoid a "communications gap" each member should be welcomed aboard upon reporting to a command. Their orientation should include introductions to key personnel, and an explanation of command policies

and functions. Questions should be answered fully to preclude any misunderstandings. If the command has a particular philosophy regarding discipline, it should be explained at this "Welcome Aboard" meeting.

While all individual performance should be recognized, not all will merit awards; some will merit reprimand, which must be administered fairly and swiftly. (Those who deserve rewards should also be recognized promptly and publicly.)

Finally, the master chief petty officer of the command, if allowed to function as intended, can help avoid a communications gap. The door to the MCPOC's office should be open at all times to every enlisted person within the command; the door to the commanding officer should be open to the MCPOC. This practice will ensure a smooth flow of communication up and down the chain of command.

—HMCM H.S. Anderson, USN, Master Chief Petty Officer of the Force, BUMED Code 006.

Morale is the most important indicator of the program's effectiveness. The morale of the organization directly influences other indicators, such as program support and discipline. As the understanding of policies increased and trust grew between the DO/LPO team and division members, morale improved; and as some of the members' beneficial suggestions were instituted, the value of the program as a way to gain recognition and satisfaction became more obvious.

With DO/LPO personnel assuming more responsibility for counseling and handling minor infractions, there was a noticeable drop in cases at mast. The number of people seen for nonjudicial punishment decreased from about 7 per week in early 1975 to 2 to 4 at year's end.

The close rapport the DO/LPO team develops with staff members helps them identify problems in the Navy's Human Goals Program, including race relations. It provides a similar opportunity for early identification of individual problems in professional and military development.

NEW WATCH ASSIGNMENTS

Among the operational problems brought up for command consideration was the issue of equitable watch. When a work study showed considerable inequity in the enlisted watch schedules, NRMC Great Lakes began to develop a new watch assignment system. Watch standers will be organized into eight divisions, each headed by a Medical Service Corps lieutenant commander as division senior watch officer. Since some functional departments have fewer than eight watch standers, effective cross-training of personnel in the divisions is necessary, and there are sure to be exceptions. Each division will be assigned to train as a unit and will rotate watchers. We hope this new system will further promote a sense of *esprit de corps* among the divisions and staff, with cross-training as a side benefit.

The drawbacks of the program are minimal considering its value as a management tool. Some say that the time DO/LPO personnel spend counseling members in their charge should be devoted to routine duties at the medical center. But we believe the results of the program clearly justify this investment of time.

The effectiveness of the program was tested recently at Great Lakes when austere funding required drastic command actions. Many programs normally taken for granted were reduced or dropped, and staff members were required to perform some tasks usually assigned to civilian public works personnel. The positive attitude and strong support by all hands was commendable.

The early results of the DO/LPO program cannot be considered conclusive, but our experience so far suggests that this basic shipboard concept, when modified to fit the needs of a naval regional medical center, is a practical adjunctive management system.

Policy

Instructions and Directives

Navy Health Records

On 1 July 1976, a major change takes place in the management and disposition of the health and dental records of Navy personnel separated from active duty on or after that date. These records will be closed and immediately delivered to the command maintaining the individual's service record. The health and dental record will thereafter always remain with the service record.

This change does not pertain to the records of Marine Corps personnel who separate from active service. Their closed-out health and dental records will continue to be forwarded to BUMED.

This change is Phase III of BUMED's implementation of the Master Medical Record concept, under which naval service personnel have only one health and dental record. In Phase I, the medical and dental records maintained at BUMED on active-duty Navy and Marine Corps personnel were returned to the individual's command for incorporation into his health and dental record. During Phase II, all medical and dental records held by BUMED on inactive duty Navy Reservists will be sent to the Naval Reserve Personnel Center, New Orleans. Records of drilling Navy Reservists will be sent to their commands. Phase II does not pertain to records of Marine Corps personnel.

See forthcoming Change 88 to the *Manual of the Medical Department* for details.

New physical standards for aviation personnel

Flight surgeons should be aware of revised physical standards for flight personnel contained in Change 87 to the *Manual of the Medical Department*:

- Because of the shortage of flight surgeons in designated billets, clinicians with previous flight surgeon designation will be allowed to perform aviation physical examinations. Such examinations are normally done by a flight surgeon or aviation medical officer on active duty in a flight surgeon billet or in an authorized aviation activity. However, when an operational flight surgeon is not available, a non-

operationally assigned flight surgeon or aerospace medical examiner, or a certified aviation medical officer may substitute.

- A positive test for sickle cell trait or disease is a disqualifying defect for duty involving frequent flights. All Class 1 and Class 2 officers and officer candidates will be tested for sickle cell trait before starting flight training. Enlisted personnel with no prior sickle cell trait test on their health record will be tested before entering flight status. Civilians of ethnic origin known to have a high abnormal hemoglobin rate will be tested for sickle cell trait when they apply for programs that involve flying; if tests are positive for sickle cell trait, these individuals are ineligible for flight status.

- Aircontrolmen are no longer under the aviation weight standard. They must now meet general service weight standards.

- Hearing standards for all applicants, officer and civilian, for the Naval Flight Officer Program have been changed to coincide with hearing standards for commissioning.

These changes apply to vision standards for Class I, Service Group 1 flight personnel:

- Accommodation may be substituted as a test for near vision. Successful accomplishment of either the accommodation test or the near vision test satisfies normal near vision requirements.

- The near point of convergence is changed from 70 mm to 100 mm. Thus, a point of convergence greater than 100 mm is disqualifying.

These changes in vision standards apply to candidates for flight training:

- Prism divergence testing is deleted.

- The limit on hyperphorias is changed from 1.0 to 1.5 prism diopters.

- Applicants who have altered their uncorrected distant vision with contact lenses should be identified. All applicants must sign a statement saying that they have never used contact lenses and that their uncorrected vision has never been less than 20/20. If the applicant cannot sign this statement, the examiner must make a full explanation, including an ophthalmology consultation.

These changes in vision standards apply to Class 2 personnel:

- Navy naval flight officer (NFO) candidates should have distant visual acuity correctable to 20/20 in each eye. If uncorrected distant visual acuity is less than 20/40, glasses will be worn during flight duty. Marine Corps NFO candidates should have uncorrected distant visual acuity in each eye not over 20/200, correctable to 20/20 in each eye; they should

wear corrective lenses while on flight duty if uncorrected visual acuity is less than 20/40. All NFO applicants must meet certain refractive standards set forth in the *Manual of the Medical Department* [15-13(4)(a)(2)(Table 3)].

- When uncorrected distant visual acuity is less than 20/40, vision must be corrected to 20/20 while on flight duty. The person must carry an extra pair of glasses while flying if uncorrected distant visual acuity is less than 20/100.

- For crewmembers and enlisted parachute jumpers as well as naval flight officers, distant visual acuity must be correctable to 20/20 in each eye. If uncorrected distant visual acuity is less than 20/40, correction to 20/20 must be worn while on flight or parachute jumper duty.

- Eye standards for student naval flight surgeons to solo have been changed from Service Group I standards to Service Group II standards.

Handling baggage in aeromedical evacuation

New procedures for handling patients' baggage throughout the Military Airlift Command aeromedical evacuation system are set forth in the enclosure to BUMED Instruction 4650.7C of 6 April 1976.

Physical Examinations for Divers

Officers assigned to diving duty will undergo medical examinations within 30 days of their 24th, 27th, 30th, 33rd and 36th birthday, and annually after that. There are two exceptions: saturation and experimental divers will be examined within one month of their birth date, regardless of age. Change 87 to the *Manual of the Medical Department* deletes a conflict with these requirements.

Enlisted divers will continue to be examined within 3 months of their 18th, 21st, 24th, 27th, 30th, 32nd, 34th, 36th, 38th, and 40th birthday, and annually thereafter.

Care of grease gun/paint sprayer injuries

People who use grease guns or paint sprayers risk injecting grease, paint, or other debris into the skin, particularly into their fingers and hands. Air-powered grease guns and paint sprayers operate at pressures up to 7,000 lbs. per square inch and can inject material at rifle speeds. Injected material can be driven great distances through the tissues.

Although the injury appears deceptively minor at first—the entry wound is usually less than 2 mm—extensive internal tissue damage causes great pain. Since circulation is impaired, damage increases with time, and the injury may produce life-

endangering infection. Frequently, the body part must be amputated.

Surgical experience shows that early decompression and debridement is the best treatment. Medical personnel should:

- Consider any injury serious in which a high-pressure air or hydraulic system injects foreign matter into the tissues.
- Be alert for associated injury. The wounded person may fall from a ladder or working platform, injuring other body parts. Pain from the injection injury may divert attention from other injuries; for instance, fainting from pain is hard to distinguish from unconsciousness caused by a head injury.
- Keep the patient prone, unless associated injuries dictate otherwise. Treat him for shock with due regard for associated injuries.
- Do not let the victim eat, since he will probably need emergency surgery. His lips may be moistened with a clean wet cloth or gauze.
- Give no medication by mouth.
- For severe pain, inject one syrette (16 mg) of morphine or an equivalent analgesic, and send with the patient a report of the medication, dose, and time given. Be wary of giving sedatives if there is an associated head injury.
- Refer the victim immediately for emergency surgical consultation.
- Transport the victim by litter.
- Have someone stay with the victim during emergency treatment and transport to protect his airway if vomiting or unconsciousness occurs.
- Do not apply hot soaks, or attempt to drain or squeeze injected material from the wound. These procedures are ineffective and can cause more tissue damage.
- Report all grease gun/paint sprayer type injuries on MED 6260-1 or by letter report (MED 6260-4) to BUMED Code 55.—BUMED Instruction 6260.20 of 20 January 1976.

Reporting alcohol treatment and rehabilitation

Instructions for reporting information on Navy alcohol treatment and rehabilitation programs have been revised. Each report quarter, naval medical facilities shall submit to regional medical centers MED 6300-7 on form NAVMED 6300/10 (revised January 1976). Reports should include information on all patients treated or rehabilitated for alcohol abuse. Regional medical centers should submit consolidated regional reports to the Naval Medical Data Services Center. Nonregionalized commands should send reports directly to Naval Medical Data Services

Center. Reports must be postmarked by 2400 of the fifth working day after the end of the report quarter. Forward to: Commanding Officer, Naval Medical Data Services Center, National Naval Medical Center, Bethesda, Maryland 20014.—BUMED Instruction 6330.2 of 5 February 1976.

Tri-Service Policy on Cosmetic Surgery

The three military medical services have adopted this policy concerning cosmetic surgery:

As defined by the American Medical Association, cosmetic surgery is surgery done to revise or change the texture, configuration, or relationship of contiguous structures of any feature of the human body which would be considered by the average prudent observer to be within the broad range of "normal" and acceptable variation for age and ethnic origin, and which is performed for a condition judged by competent medical opinion to be without potential for jeopardy to physical or mental health.

Certain cosmetic procedures are a necessary part of training and retention of skills to meet the requirements of certification and recertification. Insofar as they meet minimum requirements and serve to improve the skills and techniques needed for reconstructive surgery, cosmetic procedures may be done as low priority surgery when time and space are available.

Cosmetic facial rhytidectomies (face lifts) shall be a part of all training programs required by certifying boards. Cosmetic augmentation mammoplasties will be done only by properly credentialed surgeons and residents within surgical training programs to meet the requirements of certifying boards.—BUMED Instruction 6460.8 of 19 February 1976.

Participation in Regional Medical Programs

Commanding officers of naval medical facilities are encouraged to participate in civilian regional medical programs, provided such participation does not interfere with military responsibilities. They may help regional medical programs in research, training, and continuing education efforts, for example, as well as patient care demonstrations and related activities. Normally this help will not include patients otherwise ineligible for military care, conducting research irrelevant to Navy needs, direct fund expenditure, or sharing naval medical equipment. There should be no significant commitment of naval resources without prior BUMED approval.

Currently, regional medical programs exist to combat heart and kidney disease, cancer, and stroke.—BUMED Instruction 5700.2A of 10 March 1976.

Clinical Notes

Propranolol in Migraine Prophylaxis

LCDR Russell C. Packard, MC, USN

The pathogenesis of migraine is not completely known. The role of vasoconstriction and vasodilation seems well established, but the roles of vasoactive amines, humoral factors, and the possible effects of changes in membrane permeability in capillary vessels, remain mostly enigmatic. Thus, there is no strict rationale for using propranolol in migraine prophylaxis.

Some of the effects of beta-receptor antagonists may, however, explain propranolol's ability to prevent attacks:

- The vasoconstrictor effect may inhibit extracranial, reactive vasodilation in the headache phase.
- The local anesthetic, membrane-stabilizing effect may reduce both the pain caused by the vasodilation and the secondary pericapillary edema.
- Reduction in the glycogenolysis and glycolysis in the brain (1) may result in reduction of the rate of vasoactive amines.

Several studies (2,3) have reported propranolol to be more effective than placebo in migraine prophylaxis; but at least two other studies (4,5) using other B-blocking agents have shown little or no effect. The effectiveness of the different beta-receptor blocking agents in treating migraine may therefore vary.

Patient selection is important. Specifically, patients with heart failure, asthma, and heart block must not be treated with propranolol. The optimal antimigraine dose of propranolol is not known; however, there is a wide range in oral dosage requirement among different persons due to difference in receptor sensitivity or to pharmacokinetic factors (6). It is customary to build the dose up gradually from 40 mg. daily (in divided doses) to 160 mg. daily. The drug should be used for at least three or four weeks to assure an adequate trial. The decision to use propranolol for migraine prophylaxis depends upon the preference of the individual physician, but such factors as a poor response to the usual remedies (such as ergotamine preparations), or loss of work

because of migraine headache seem adequate indications.

Side effects of propranolol are minor, the most common being general fatigue and lethargy. In insulin-dependent diabetic patients, warning symptoms of impending hypoglycemia may be obscured. Withdrawal of the drug should be carried out by gradually tapering the dose over a two-week period.

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DON'T MISS

Educating Postmyocardial Infarction Patients

Naval health researchers have developed a questionnaire to evaluate the knowledge postmyocardial infarction patients have about their disease, its psychological effects, emergency treatment, diet and smoking adjustments, physical activity, and problems to expect on returning to home and work. CDR Richard H. Rahe, MC, USNR, Cynthia Scalzi, M.N., and Kenneth Shine, M.D. report on the questionnaire in *Heart and Lung* 4(5):759-766, Sep-Oct 1975.

Copies are available from Naval Health Research Center, San Diego, California 92152; ask for Report No. 74-43.

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Human Energy Requirements: A Simple Tool for Assessment in a Weight Control Program

LT Steven R. Lamar, MSC, USN

The Navy has recently paid considerable attention to weight control, physical fitness, and the appearance of naval personnel (1,2,3,4). The Secretary of the Navy has directed commanding officers to identify overweight men and women, and to institute prevention and treatment programs; medical officers have been directed to pay particular attention to weight during physical examinations, and to help commands treat overweight personnel. The Marine Corps, too, has started a strict weight control program, with a lower maximum weight standard for active-duty personnel (5). Because of the impetus from high command levels and increasing evidence relating obesity to chronic diseases, many medical commands need guidance on how to implement weight control programs.

In "Energy Metabolism and Weight Control" (6), I dealt with the theoretical aspects of human energy balance, pointing out that the body needs energy for four major activities: basal metabolism, muscular activity, tissue growth and repair, and specific dynamic action (the energy needed to process food). For weight loss to occur, the energy expended for these functions must exceed dietary energy

(calorie) intake: the dieter must increase physical activity, decrease food intake, or do both.

Controlled-calorie diets and progressively demanding exercise are routinely prescribed for weight reduction. But before one can recommend effective diet and exercise programs, one must know the patient's energy expenditure, caloric intake, and energy required to maintain present weight.

This paper presents a method for assessing metabolic, activity and dietary needs—a method recommended by physicians, dietitians, and clinical counselors who treat overweight patients. Although a complete weight control program should meet the patient's individual needs, the following guidelines can be used in the initial screening and work-up of *all* overweight men and women. The work-up determines calories required for basal metabolism, calories needed for muscular activity, total energy requirement to

maintain present weight, present caloric intake, and an appropriate diet and exercise regimen based on the preceding data.

OBESITY WORK-UP

The first step in the obesity work-up is to acquire preliminary and body weight data. A fictional patient's data is recorded in Figures 1 and 2.

To determine the energy needed to maintain present body weight, calories required for basal metabolism and muscular activity are computed, along with an estimate of total energy requirement (Figure 3).

Energy used for muscular activity is determined by recording a patient's activities during a typical day (Figure 3II). The patient may record his activities for 24 hours, or his clinical counselor may write the record after interviewing the patient. All similar activities should be grouped together, with additional

Name: John Doe Social security number: 000-00-0000 Date: 8 Mar 1976
Age: 25 Sex: M Height: 5 feet 10 inches
Present weight: 222 lbs

FIGURE 1. Preliminary Data

Frame: Medium Desirable weight: 146 to 160 lbs (Table I)
Maximum weight, Marine Corps and Navy aviation personnel standard: 192 lbs (Table II)
Recommended weight loss: 30 lbs

FIGURE 2. Body Weight Data

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activities added as needed (see Table V). The clinical counselor, rather than the patient, should make final calculations.

We can now use the energy requirements for basal metabolism and muscular activity to estimate the average energy needed each day to maintain present body weight (Figure 3III). This estimate is adjusted for the lower basal metabolism rate during sleep and for the influence of specific dynamic action.

To determine present caloric intake, the patient should keep a 3-day (72-hour) record of food intake, specifying what and how much he ate, with a general description of ingredients (such as in casseroles and salads). The patient should record typical days, and should not change his eating habits to improve the evaluation. The purpose of collecting a dietary history is not to see how good the prospective dieter can be, but to gauge his real dietary habits, from which a reasonable assessment of his energy intake can be made. Total caloric intake for each of the 3 days is determined, and the average intake recorded (Figure 4, line B). Accurate caloric data on foods can be obtained from "Food Values of Portions Commonly Used" (11).

RECOMMENDED DIET PLAN

It is now possible to recommend a realistic diet and exercise program. By completing Figure 4, the patient and clinical counselor can predict the anticipated rate of weight loss and the time required to reach the prescribed weight goal. The recommended safe weight loss rate of 2 pounds per week (12) can be achieved with a daily deficit of 1,000 calories. For example, our hypothetical patient, John Doe, requires 3,605 calories per day to maintain his present body weight, but is consuming 3,800 calories. Since we want him to lose 2 pounds per week, we recommend a daily intake of 2,600 calories (some 1,200 calories

I. Calories Required for Basal Metabolism				
A) Height in centimeters (inches x 2.54)				177.8
B) Weight in kilograms (lbs ÷ 2.2)				100.9
C) Surface area in square meters (determine from Table III)				2.2
D) Calories per square meter per day (determine from Table IV)				921.6
E) Calories required for basal metabolism (multiply C x D)				2028 (Record in Figure 3, Section III, line A)

II. Calories Required for Muscular Activity: 24-Hour Activity Record				
Activity	Hours spent in activity	Calories per kg per hour (Table V)	Weight (kg)	Energy cost (time x cal/kg/hr x weight)
Lying still, awake	0.5	0.1	100.9	5
Dressing and undressing	1.0	0.7	100.9	71
Standing	4.5	0.6	100.9	272
Sitting, writing, eating, reading	5.0	0.4	100.9	202
Walking, light exercise	1.5	1.4	100.9	212
Driving car	1.0	0.9	100.9	91
Playing cards	0.75	0.5	100.9	38
Football	0.5	6.8	100.9	343
Walking rapidly	0.5	3.4	100.9	172
Typing rapidly	0.75	1.0	100.9	76
Sleeping	Record time spent sleeping in Section III, line D			
Calories required for muscular activity				1482 (Record in Section III, line B)

III. Estimate of Total Energy Requirement	
A) Calories required for basal metabolism (from Section I, line E)	2028
B) Calories required for muscular activity (from Section II)	1482
C) Total calories for basal + activity (block A + block B)	3510
D) Time spent sleeping per day: <u>8</u> hrs (<u>8</u> hrs sleep) x (weight <u>100.9</u> kg) x (0.1)	81
E) Calories required for specific dynamic action of food: block C x 5%	176
F) Total energy requirement (block C - block D + block E)	3605 calories

FIGURE 3. Estimate of Total Energy Requirement

FIGURE 4. Diet Plan and Projected Weight Loss Data

A) Total energy requirement (from Figure 3III, line F)	3605 calories/day
B) Present average caloric intake	3800 calories/day
C) Recommended intake for weight loss	2600 calories/day
D) Additional recommended dietary modifications	4 gm sodium/day less than 300 mg cholesterol/day P/S ratio = 2:1*
E) Recommended weight loss	30 lbs
F) Anticipated rate of weight loss	2 lbs/week
G) Anticipated time required to achieve weight goal	15 weeks

*P/S ratio = polyunsaturated fatty acids \div saturated fatty acids.

TABLE I. Desirable Weight in Pounds According to Frame (7) (in indoor clothing)

Desirable Weight for Men Age 25 and Over*				
Height with Shoes (1-inch heels)		Small Frame	Medium Frame	Large Frame
Feet	Inches			
5	2	112-120	118-129	126-141
5	3	115-123	121-133	129-144
5	4	118-126	124-136	132-148
5	5	121-129	127-139	135-152
5	6	124-133	130-143	138-156
5	7	128-137	134-147	142-161
5	8	132-141	138-152	147-166
5	9	136-145	142-156	151-170
5	10	140-150	146-160	155-174
5	11	144-154	150-165	159-179
6	0	148-158	154-170	164-184
6	1	152-162	158-175	168-189
6	2	156-167	162-180	173-194
6	3	160-171	167-185	178-199
6	4	164-175	172-190	182-204

*For nude weight, deduct 5 to 7 lbs.

Desirable Weights for Women Age 25 and Over*				
Height with Shoes (2-inch heels)		Small Frame	Medium Frame	Large Frame
Feet	Inches			
4	10	92-98	96-107	104-119
4	11	94-101	98-110	106-122
5	0	96-104	101-113	109-125
5	1	99-107	104-116	112-128
5	2	102-110	107-119	115-131
5	3	105-113	110-122	118-134
5	4	108-116	113-126	121-138
5	5	111-119	116-130	125-142
5	6	114-123	120-135	129-146
5	7	118-127	124-139	133-150
5	8	122-131	128-143	137-154
5	9	126-135	132-147	141-158
5	10	130-140	136-151	145-163
5	11	134-144	140-155	149-168
6	0	138-148	144-159	153-173

*For nude weight, deduct 2 to 4 lbs.

TABLE II. Weight Standards for Marine Corps and Navy Aviation Personnel (5,8)

Men																
Height (inches)																
64	65	66	67	68	69	70	71	72	73	74	75	76	77	78		
Weight (lbs)																
Minimum																
105	106	107	111	115	119	123	127	131	135	139	143	147	151	153		
Maximum																
160	165	170	175	181	186	192	197	203	209	214	219	225	230	235		

Women																
Height (inches)																
58	59	60	61	62	63	64	65	66	67	68	69	70	71	72		
Weight (lbs)																
Minimum																
90	92	94	96	98	100	102	104	106	109	112	115	118	122	125		
Maximum																
121	123	125	127	129	135	136	140	144	147	152	158	162	168	171		

TABLE III. Chart for Determining Body Surface Area (9)

To determine your body surface area, locate your height on the left axis and your present weight on the right axis. Draw a straight line between these points. The value where this line crosses the center axis is your body surface area in square meters.

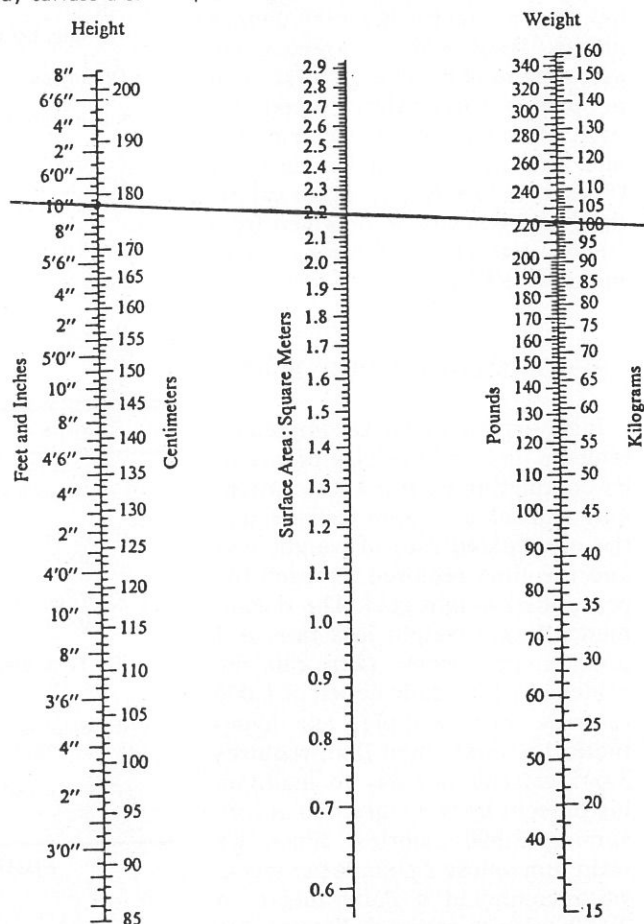


TABLE IV. Basal Metabolism Standard (10)

To determine your energy requirement (calories) per body surface area, select the caloric value which corresponds to your age and sex and multiply by square meter determined in Table III.

Age	Calories per square meter per day	
	Males	Females
5	1351.2	1272.0
6	1296.0	1228.8
7	1255.2	1192.8
8	1219.2	1152.0
9	1188.0	1108.8
10	1144.8	1077.6
11	1116.0	1044.0
12	1087.2	1008.0
13	1068.0	972.0
14	1051.2	940.8
15	1029.6	919.2
16	1008.0	892.8
17	996.0	873.6
18	979.2	859.2
19	972.0	849.6
20	957.6	847.2
21	948.0	844.8
22	940.8	844.8
23	936.0	844.8
24	928.8	842.4
25	921.6	842.4
26	916.8	840.0
27	912.0	840.0
28	907.2	840.0
29	904.8	840.0
30	902.4	840.0
31	897.6	840.0
32	892.8	837.6
33	890.4	837.6
34	888.0	837.6
35	885.6	835.2
36	883.2	832.8
37	880.8	830.4
38	880.8	828.0
39	878.4	825.6
40-44	873.6	818.4
45-49	868.8	811.2
50-54	859.2	794.4
55-59	842.4	787.2
60-64	828.0	768.0
65-69	804.0	758.4
70-74	784.8	746.4
75+	763.2	

TABLE V. Energy Cost of Activities (10)

(Exclusive of basal metabolism and influence of foods)

Activity	Calories per kg per hr
Bedmaking	3.0
Bicycling (high speed)	7.6
Bicycling (moderate speed)	2.5
Boxing	11.4
Carpentry (heavy)	2.3
Cello playing	1.3
Cleaning windows	2.6
Crocheting	0.4
Dancing, moderately active	3.8
Dishwashing	1.0
Dressing and undressing	0.7
Driving car	0.9
Eating	0.4
Exercise	
Very light	0.9
Light	1.4
Moderate	3.1
Severe	5.4
Very severe	7.6
Fencing	7.3
Football	6.8
Gardening, weeding	3.9
Golf	1.5
Horseback riding (trot)	4.3
Ironing (5 lb iron)	1.0
Knitting sweater	0.7
Laboratory work	2.1
Laundry, light	1.3
Lying still, awake	0.1
Office work, standing	0.6
Painting furniture	1.5
Paring potatoes	0.6
Playing cards	0.5
Playing ping pong	4.4
Piano playing	0.8
Reading aloud	0.4
Rowing	9.8
Rowing in race	16.0
Running	7.0
Sawing wood	5.7
Sewing, hand	0.4
Sewing, foot-driven machine	0.6
Sewing, electric machine	0.4
Singing in loud voice	0.8
Sitting quietly	0.4
Skating	3.5
Skiing (moderate speed)	10.3
Standing at attention	0.6
Standing relaxed	0.5
Sweeping with broom	1.4
Sweeping with carpet sweeper	1.6
Sweeping with vacuum cleaner	2.7
Swimming (2 miles per hr)	7.9
Tailoring	0.9
Tennis	5.0
Typing, rapidly	1.0
Typing, electric typewriter	0.5
Violin playing	0.6
Walking (3 miles per hr)	2.0
Walking (4 miles per hr)	3.4
Walking at high speed (5 miles per hr)	8.3
Walking down stairs	*
Walking up stairs	**
Washing floors	1.2
Writing	0.4

*Allow 0.012 calorie per kilogram for an ordinary staircase with 15 steps, without regard to time.

**Allow 0.036 calorie per kilogram for an ordinary staircase with 15 steps, without regard to time.

less than his actual intake). At this rate, Mr. Doe should achieve his recommended weight loss of 30 pounds in 15 weeks. Since a physical examination showed that Mr. Doe has high blood pressure and an elevated serum cholesterol level (Type IIa hyperlipoproteinemia), his 2,600 calorie diet will also include less sodium, cholesterol, and saturated fat.

Medical commands responsible for initial screening and work-up of obese patients should find this energy assessment method a useful clinical tool to determine the preliminary data needed to formulate effective diet and exercise plans.

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Sublingual Dermoid Cyst:

Report of a Case

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CAPT B.J. DeVos, DC, USN

Dermoid cysts of the floor of the mouth are rare, comprising only 0.01% of all oral cystic lesions. These cysts may be either congenital or acquired. The congenital cysts arise from inclusion of ectoderm, with or without dermal appendages, when the neural groove is closed; or they result from the coalescence of other epithelial lines of fusion (1). Some of the cysts may be formed from remnants of the tuberculum impar of His which, together with the lateral process from the inner surface of each mandibular arch, form the body of the tongue and the floor of the mouth. This inclusion occurs during the third and fourth week of intrauterine development (2). Acquired dermoid cysts, which comprise less than 10% of reported cases, may result from trauma, iatrogenesis, or occlusion of hair follicles or sebaceous glands. Of 1,495 cases of dermoid cysts studied at the Mayo Clinic between 1910 and 1935, only 103 cases occurred in the head and neck; 24 were in the floor of the mouth, an incidence of only 1.6%. Fewer than 200 cases of oral dermoid cyst have been reported since 1859 (1).

Dermoid cysts have been classified into three groups:

Epidermoid cyst. A cyst whose epithelial-lined wall is derived from epidermis and supporting connective tissue, and contains no dermal appendages.

Dermoid cyst. A cyst with a similar epithelial-lined cavity, but which contains dermal appendages such as hair, hair follicles, sebaceous glands and sweat glands in the underlying connective tissue.

Teratoma. A lesion usually described as containing a disorderly arrangement of tissues and organs. It has an epithelial-lined cavity as well as mesodermal and endodermal elements such as

muscle, intestinal mucosa, respiratory mucosa, bone, blood vessels, and dermal appendages (2).

Mosby, Robertson and Sugg (3) have proposed another classification. They would maintain "dermoid cyst" as the clinical term, and use the following terms for histological examination:

Simple dermoid cyst of the floor of the mouth contains no dermal appendages.

Compound dermoid cyst of the floor of the mouth contains one or more skin appendages.

Complex dermoid cyst of the floor of the mouth contains elements from all three germ layers.

In this case report, I will use the traditional classification most commonly found in published studies.

SYMPTOMS AND TREATMENT

The dermoid cyst is rarely seen at birth. It most frequently occurs in people aged 15-35 years; there is no predilection for sex. The lesion usually appears in the midline and may be above (sublingual) or below (submental) the mylohyoid muscle. Very rarely, the cyst may be located between the medial surface of the mandible and the musculature of the tongue (1). The weight can vary from one to several hundred grams and the capacity from a few to more than 1,000 cubic centimeters. Not a fluid sac, the lesion is instead filled with a yellowish caseous material derived from the cyst wall. When palpated, the lesion usually has a doughy texture (2). The mucosa overlying the cyst may vary in color from normal to yellow depending on the depth of the lesion below the mucosa (3).

Symptoms may include a slowly enlarging intra-oral swelling in the floor of the mouth, which may cause displacement of the tongue with resultant difficulty in eating, talking and breathing. Extraoral swelling resembling a double chin may develop. The lesion retains pitting after pressure has been

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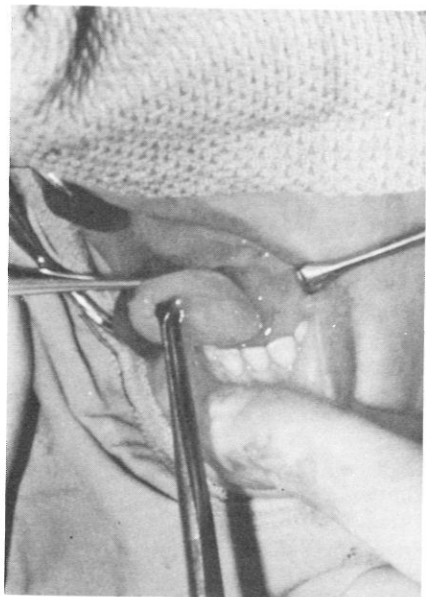


FIGURE 1. The cystic mass is delivered from the midline of the floor of the mouth.

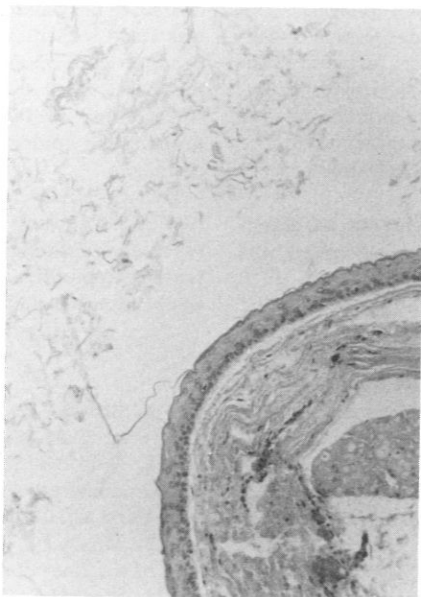


FIGURE 2. This medium-power photomicrograph shows a cystic wall lined with squamous epithelium.

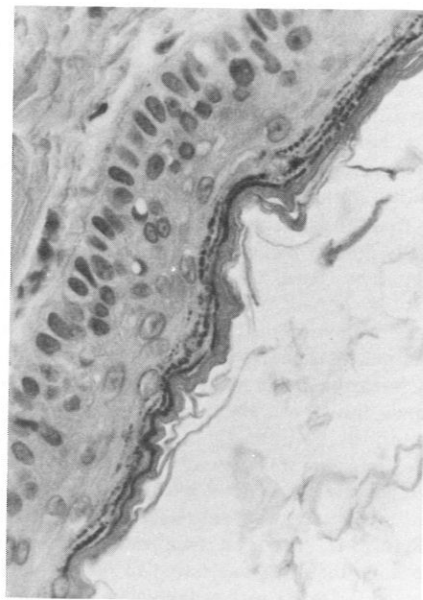


FIGURE 3. High-power photomicrograph of the cyst wall.

applied. Sinus tracts, opening either intraorally or extraorally, may develop. There is usually no pain associated with the lesion unless infection is present or the mass exerts pressure on the lingual nerve. The most unfavorable sequelae of this lesion are that it may undergo malignant change and then metastasize to the lymph nodes.

A thorough differential diagnosis is essential to distinguish the dermoid cyst from several other lesions that occur in the midline of the floor of the mouth. If the mass is above the mylohyoid, the entities to be considered are ranulas, sublingual abscesses, and benign or malignant tumors of the mouth. A mass located below the mylohyoid may be confused with blocked submaxillary ducts, a thyroglossal duct cyst, a cystic hygroma, a branchial cleft cyst, or submaxillary sialadenitis (1,2).

One of the most unusual cases of dermoid cyst involved a sublingual cyst in a patient who had congenital ankyloglossia, which was separated in infancy. This patient had what appeared to be two distinct dermoid cysts—one sublingual, the other in the tip of the tongue—both with protruding hairs. It was suggested that the cysts were part of a single lesion—a sublingual dermoid cyst that had been the cause of the ankyloglossia.

The dermoid cyst requires surgical excision. The lesion is easily removed with blunt dissection unless it has been treated with sclerosing solution or is

infected. A transoral approach is used for sublingual cysts; an extraoral approach is recommended for submental lesions.

Diagnostic aspiration of the cyst should be avoided, since infection may result that would complicate an otherwise easy surgical removal. However, the lesion should be aspirated at surgery to rule out the possibility of angioma. If the lesion is already infected, aspiration may be used for temporary relief (1,2).

A complicating factor in removal of the dermoid cyst is administration of anesthesia. When the tongue is displaced and direct vision of the larynx impossible, several methods for administering general anesthesia are available if local anesthesia is insufficient. The lesion may be decompressed before attempting intubation; a catheter may be passed in a retrograde fashion through the cricothyroid membrane into the mouth, with a tracheal tube then threaded into the larynx; or a tracheostomy may be performed (4).

CASE REPORT

An 18-year-old seaman recruit was seen at the Dental Department, Naval Training Center, Orlando, Florida, for routine dental examination. A swelling was observed in the midline of the anterior floor of the mouth. The patient said the swelling had been present as long as he could remember. It had not increased significantly in size in the past several years.

The past history, family history, and review of systems were either negative or noncontributory to the present illness.

Physical examination revealed a well-developed, well-nourished Caucasian male in no obvious distress. Intraoral exam revealed a fluctuant, relatively superficial mass measuring approximately 3.0 centimeters in diameter in the anterior floor of the mouth; the mass was believed to be superficial to the genioglossus. The remainder of the physical examination was within normal limits.

Routine laboratory studies on admission revealed an essentially normal hemogram and urinalysis. A routine serology was negative. Chest X-rays showed no abnormalities.

On 2 October 1975 the patient was taken to the operating room for enucleation of the cyst under general anesthesia via nasotracheal tube. No difficulty was encountered during intubation. A vertical incision measuring approximately 3.5 centimeters was made into the oral mucosa inferior to the tongue and carried anteriorly between the caruncles of the submandibular ducts. The incision was extended via sharp and blunt dissection to expose the cystic mass which was lying between the genioglossae. The cyst was enucleated via sharp and blunt dissection (Figure 1). The cyst ruptured during delivery, and a yellow caseous material was found to fill the cavity. The incision was closed in layers with polyglycolic acid interrupted sutures.

The histological examination revealed a cystic wall partially

lined by squamous epithelium and aggregates of giant cells that contained fatty material in their cytoplasm. The lumen of the cyst was filled with pinkish keratin material (Figures 2 and 3). The changes were consistent with those of a partially ruptured dermoid cyst.

According to the traditional classification, this lesion was probably an epidermoid cyst, since it contained no dermal appendages.

Postoperatively the patient progressed satisfactorily; he was discharged to duty on 7 October 1975. Follow-up examinations revealed satisfactory healing. The sutures were removed on the tenth postoperative day. The patient left the training center three weeks after surgery and was lost to follow-up.

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Scholars' Scuttlebutt

It seems as if every one of our subsidy students has called or written BUMED to complain about recent changes in the tax regulation covering their subsidies. Frankly, we don't blame you a bit. Perhaps we can explain what happened.

As you know, the Armed Forces Health Professions Scholarship Program (AFHPSP) was designed to meet the Armed Forces' need for qualified physicians, dentists, and other medical specialists after the draft ended. Program participants are commissioned as Reserve officers on inactive duty while in training. During their annual 45 days of active duty, they receive grade 0-1 pay and allowances; for the remainder of the year they receive a monthly stipend of \$400. The Armed Forces pay tuition, fees, books, and laboratory expenses. All of the foregoing constitute scholarship benefits.

On completing training, AFHPSP participants are required to serve on active duty for a period of time based on length of training.

In a ruling dated 1 August 1973 the Internal Revenue Service (IRS) stated that scholarship benefits received by AFHPSP participants are not excludable from gross income as a fellowship grant. Department of Defense officials

immediately protested that the AFHPSP Program would be less attractive to students if scholarship benefits were included in the participants' gross income, and that such a policy would hamper the Armed Forces' ability to recruit medical and dental students. Responding to that concern, Congress enacted Public Law 93-483 on 26 October 1974. Under this law, scholarship benefits for 1973, 1974 and 1975 were treated as "scholarship" under section 117 of the 1974 Internal Revenue Code and were excluded from gross income. No legislation was enacted to extend this provision, however, and the IRS determined that scholarship benefits received by AFHPSP participants after 1 January 1976 would be treated as "compensation" and therefore included in gross income.

DOD then drafted new legislation that would amend section 117 of the Internal Revenue Code to provide permanent tax exclusion for stipends, tuition, fees, books, and laboratory expenses paid on behalf of AFHPSP participants. The proposed legislation was submitted to the Office of Management and Budget for approval on 22 October 1975. Because Congress might not consider this legislation until summer,

DOD asked the IRS to set a one-year moratorium on including AFHPSP scholarship benefits in gross income. This delay would give Congress sufficient time to consider and perhaps pass the proposed legislation.

On 19 February 1976, the IRS ruled that AFHPSP benefits are not "scholarships" that can be deducted from gross income, because receipt of these benefits is conditional on performing future services. The IRS also said that Congress had had enough time while P.L. 93-483 was in effect to review taxation of scholarships and fellowships; since Congress did not authorize the Treasury Department to refrain permanently from collecting tax on AFHPSP benefits, the Secretary of the Treasury says he cannot establish the moratorium requested by DOD. Therefore, as of May 1976, all benefits provided by the Armed Forces to AFHPSP students are taxable as gross income, effective 1 January 1976.

We realize that this tax takes most of your stipend each month, and we share your concern. However, the Navy has no choice but to comply with existing IRS regulations. We have every hope that Congress will soon correct this inequity through legislative action.

BUMED SITREP

NEW CO's . . . Medical Service Corps officers are being assigned as commanding officers of five more medical facilities. The new CO's are: CAPT Eugene M. Bryant, Jr. (NH Cherry Point); CAPT John D. Pruitt (NH Annapolis); CAPT Rodger F. Schindele (NH Quantico); CAPT Jay C. Smout (NH Whidbey Island); and CDR James R. Erie (NH Patuxent River). These assignments help relieve medical officers of administrative duties, freeing them for direct patient care.

MANAGEMENT BY OBJECTIVES . . . LCDR R.L. DeVault (MSC) has been named special assistant to the Surgeon General (BUMED Code 0014) as program manager for Management by Objectives (MBO).

Ten objectives have been promulgated within BUMED. The first four, along with architectural plans and action plans, originated from the CNO-appointed Navy Health Care Review Committee and constitute the CNO direction for the Navy health care system of the future. Briefly these objectives are:

- To give the highest priority to health care support of the operating forces.
- To establish and conduct a requirements-based professional education and training program.
- With Chief, BUPERS and Deputy CNO (Manpower), to issue a joint formal guidance plan on management of health care and personnel, including procedures to measure personnel utilization through selected monitoring factors.
- Through identification and evaluation, to minimize the effects of epidemiological, environmental, occupational and operational health risks.

These objectives are supplemented by six broad objectives drawn up by the Surgeon General's MBO Committee:

- To provide full preventive and curative medical and dental service to members of the active-duty naval establishment.
- To provide all possible health care to other eligible beneficiaries in the direct care system.
- To maintain a trained and experienced all-volunteer professional force.
- To design and maintain modern facilities and materiel.
- To operate the direct health services

system according to accepted principles for maximum effectiveness, efficiency, quality and accountability.

- To conduct military medical research.

BUMED codes are developing detailed action plans to accomplish the four CNO-originated objectives. In support of the six BUMED-originated objectives, codes are developing key result areas, specific goals and indicators, and action plans.

FLYING FAMILY PHYSICIANS . . .

Medical officers trained in both aerospace medicine and family practice are needed to staff Patrol Wing II squadrons at Naval Air Station Jacksonville, Florida. The goal: to form a group of medical officers who can support the fleet during deployments and care for aviation personnel and their families at the home naval air station. One billet is filled; another opens this summer, and two more are planned as more dually-trained medical officers become available. Interested officers should contact BUMED Code 511.

MANPOWER CLASSIFICATION . . .

Naval officer billet classifications (NOBC), subspecialty codes, and additional qualification (AQD) codes for Medical Department officers have been revamped. New classifications will be promulgated as Change 1 to the Navy Officer Manpower and Personnel Classifications Manual (NAVPERS 15839C). Here's a preview:

- Many NOBC titles will be revised or deleted.
- NOBCs will provide functional descriptions of billet requirements in view of changes incorporated in other classification systems.
- The Navy subspecialty system will be expanded to define the subspecialty. The education/training level within the subspecialty will be indicated by a suffix letter.
- AQD classifications will include only the qualifications generally attained by Navy functional training.

In coordination with BUMED as designator adviser, CNO will implement revised classifications for all billets with 210X, 220X, 230X, 290X, and 754X designators. Implementation of the revamped classifications will be completed during calendar year 1976.

SILVER RECOVERY . . . The Silver Recovery Program is attracting the interest of the Naval Audit Service. Defense Supply Agency has assumed responsibility for the Precious Metals Recovery Program, and will fund for all associated equipment and most charges. The Naval Medical Materiel Support Command is program manager for BUMED. Questions or requests for assistance concerning the program should be directed to NAVMEDMAT-SUPPCOM Code 25; Autovon 443-8737 or commercial (215)755-8737.

FINANCIAL MANAGEMENT . . .

The Navy is developing changes in its financial management information programs that will have a major impact on the Medical Department. The Uniform General Ledger Accounting System (UGLAS), to be implemented 1 October 1976, completely revises the current accounting system. The Uniform Management Reports (UMR) system is designed to provide accurate, more timely reports, and to be more responsive to management needs. The Integrated Disbursements and Accounting (IDA) system will be a nationwide telecommunication system of disbursing and accounting; it will improve the entry of data into the accounting system, and incorporate the disbursing process as an integral function of the system. Information regarding these changes will be sent to field activities, with implementing instructions, soon after it is received at BUMED.

ZERO BACKLOG . . . NRMC San Diego, for what is believed to be the first time in its history, has achieved a zero backlog in medical transcription. Narrative summaries and medical boards are now transcribed and ready for signature on the same day or within one day of their dictation. The CO, his fine staff, and their COMPU-TEXT System deserve sincere congratulations.

LENGTH OF STAY . . . The Systems Engineering Division (BUMED Code 023) has developed a new model for assessing length of patient stay at naval hospitals. The model compares actual length of stay in Navy hospitals with the mean length of stay at 1,801 civilian hospitals during 1974 (the objective standard). It also identifies illnesses that cause significantly long patient stays, allowing naval hospitals to monitor these diagnoses more closely.

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